

SUPERVISION AND ONGOING TRAINING FOR MARRIAGE AND
FAMILY THERAPISTS IN ACCREDITED CHILD AND
FAMILY SERVICE AGENCIES

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by
Douglas Bruce Stephens
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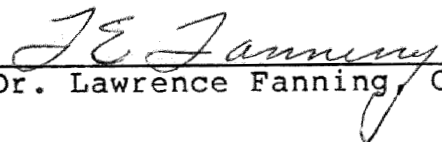
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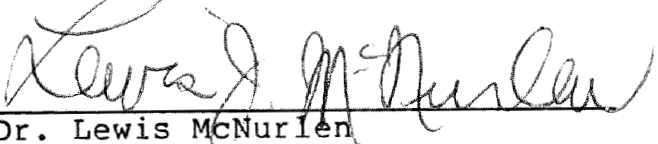
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An abstract of a Thesis by
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February 1986
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The problem. This study investigated the continuing need for supervision and training for marriage and family therapists in agencies accredited by the Council on Accreditation of Services for Families and Children.

Procedure. Twenty-six agency supervisors completed questionnaires designed to elicit information regarding their staff therapists' training, the theoretical focus for supervision, and the nature of training needs for staff. The data derived from the responses to the questionnaire answered all five of the questions under investigation.

Findings. Supervision was provided in 92 percent of the agencies surveyed. Therapists in these agencies received 1.0 hours of either group or individual supervision weekly. The majority of supervisors utilized a non-systems theoretical model for supervision but there was much diversity of therapy models chosen by the supervisors. A total of 58.5 percent of the agency therapists received no postgraduate training in marriage and family therapy from either the AAMFT format or a free-standing institute of marriage and family therapy. Less than 8 percent of the staff therapists had attained AAMFT Clinical Member status while 34 percent had received some training from an institute.

The most prevalent method used by supervisors to monitor staff training needs was therapist self-evaluation; second was the in depth regular tracking of one clinical case. There was no indication of an objective monitoring method that evaluated the developmental needs of the therapist for ongoing training.

Conclusion. Many agencies had no theoretical model to guide staff supervision or uniformity in therapy services which, along with the aforementioned statistics, indicates a dearth of theoretical integrity for marriage and family therapy supervision in many child and family service agencies.

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CHAPTER ONE

Introduction

The field of marriage and family therapy (MFT) has grown immensely during the past twenty years. The public and professional demands for available, competent MFT services have increased steadily in recent years. Community-supported child and family service agencies, such as those funded by local United Way campaigns throughout the nation, have received a steady flow of requests for MFT services as people recognize the primary influence one's family relationships have on a person's mental health. In turn, there has been a flourishing of academic MFT training programs and free-standing institutes designed to provide instruction for counselors and therapists in the work of marriage and family therapy.

As with any rapid expansion of specific human services, in this case marriage and family therapy services and the development of therapists who are qualified to provide MFT services, there has been a developing concern about the dearth of empirical data regarding training and supervision

in this field.¹ Training is a method of instruction that is time-limited which occurs between an experienced therapist (trainer) and less-experienced therapists. No emphasis is made on the personal relationship between the trainer and students, nor does the trainer assume responsibility for the quality of ongoing work done by the students or trainees. Supervision differs from training as it presupposes a hierarchical authority chain of case responsibility and oftentimes supervisor and supervisee are on the same agency staff.

The conceptual and research efforts in the areas of training and supervision have developed at a slower rate than the progress made with therapists' efforts in marriage and family therapy.² Much of this imbalance can be attributed to the tendency by therapists to devise methodologies of therapy designed to impact on the acute problems of clients seen in their consultation rooms. They desire interventions that work. Having sound research that

¹F. Kersey, "Supervisory Process and Focus Applied in the Development and Training of Marriage and Family Therapists," Diss., Univ. of Iowa, 1982; R. Whiffen and J. Byng-Hall, eds., Family Therapy Supervision: Recent Developments in Practice (New York: Grune and Stratton, 1982).

²H. A. Liddle and R. J. Halpin, "Family Therapy Training and Supervision Literature: A Comparative Review," Journal of Marriage and Family Counseling, 4 (1978), 77-90; D. Kniskern and A. Gurman, "Research and Training in Marriage and Family Therapy," in Dimensions of Family Therapy, eds. M. Adolphi and I. Zwerling (New York: Guilford, 1980), pp. 221-38.

pinpoints which methods are more universally effective explains why they work, and how to teach therapists these methods is at best an afterthought for most therapists who have little time left after seeing a full caseload of client appointments each week. And yet, without sound bases for training and supervision, there can be no adequate response to these therapists' requests for learning in new areas of increasingly complex human problems. Only recently have advances been made on the building of theoretical paradigms for MFT supervision and training.¹ For the most part, models are taught either as part of an academic graduate program or in institutional settings designed to provide time-limited, post-graduate training in marriage and family therapy.²

To date there are no formal theories or comprehensive

¹H. Liddle and G. Saba, "Teaching Family Therapy at the Introductory Level: A Conceptual Model Emphasizing a Pattern which Connects Training and Therapy," Journal of Marital and Family Therapy, 8, No. 1 (1982), 63-72.

²E. Berman and T. Dixon-Murphy, "Training in Marital and Family Therapy at Free-standing Institutes," Journal of Marital and Family Therapy, 5, No. 3 (1979), 77-82; F. S. Duhl and B. S. Duhl, "Structured spontaneity: The Thoughtful Art of Training in Integrative Family Therapy at BFI," Journal of Marriage and Family Therapy, 5 (1979), 59-76; R. Garfield, "Family Therapy Training at Hahnemann Medical College and Hospital," in Dimensions of Family Therapy, eds. I. Zwerling and M. Andolfi (New York: Guilford, 1980), pp. 261-72; K. LaPerriere, "Family Therapy Training at the Ackerman Institute: Thoughts of Form and Substance," Journal of Marital and Family Therapy, 5, No. 3 (1979), 53-58; I. Rosenbaum and A. Serrano, "A Rationale and Outline for a Training Program in Family Therapy,"

models of marriage and family therapy supervision due to the fragmented empirical studies in the field.¹ Training and supervision programs are usually based upon the notable clinical experience of a particular therapist/trainer, with limited research data to support the methodology.²

Coupled with the lack of well-defined, empirically-sound supervision models, only recently has the issue of the developmental stages for MFT training and supervision been specifically investigated. Kersey found that while developmental issues had been studied by various authors in the counseling and therapy profession, the specialty of MFT had been addressed by few MFT professionals, apart from Fisher.³ This need for a model that addresses sequentially the developmental stages of MFT training and supervision is

Journal of Marital and Family Therapy, 5, No. 3 (1979), 77-82; M. D. Stanton, "Family Therapy Training: Academic and Internship Opportunities for Psychologists," Family Process, 14, No. 4 (1975), 433-39; K. Tomm and L. Wright, "Multilevel Training and Supervision in an Outpatient Service Program," in Family Therapy Supervision: Recent Developments in Practice, eds. R. Whiffen and J. Byng-Hall (New York: Grune and Stratton, 1983), pp. 211-28.

¹Kersey, "Supervisory Process and Focus Applied in the Development and Training of Marriage and Family Therapists," pp. 1-156; Whiffen and Byng-Hall, pp. 3-16.

²F. W. Kaslow, "Training of Marital and Family Therapists," in Supervision, Consultation, and Staff Training in the Helping Professions, ed. F. Kaslow (San Francisco: Jossey-Bass, 1977), pp. 199-234.

³B. Fisher and T. Embree, "Supervision of Beginning and Advanced Marital and Family Therapists: A Comparative Study," American Association of Marriage and Family Therapy, Houston, Texas, October, 1981.

especially important for use in accredited child and family service agencies. These community-based agencies provide MFT services on a sliding fee basis, with the philosophical mission included for professional staff and the agencies' boards that no persons be turned away because of their inability to pay for this service. Such a service provision requires of staff marriage and family therapists that they be both generalists and highly adept with specific problems that beset couples and families. Accredited child and family service (CFS) agencies, therefore, often find themselves employing lesser-skilled therapists with varied levels of training due to the limited funding possible through the local United Way. This situation hints at the dilemma of how to maintain a highly-skilled staff of therapists at relatively modest salaries. The training and supervision needs for marriage and family therapy staff in child and family service agencies are yet to be formally documented. However, in order to increase the professional quality and effectiveness of service delivery, CFS agencies might consider ways of developing a training and supervision framework which might keep marriage and family therapy staff sharp in their clinical skills. Prior to formulating such a framework model which might be applied in many diverse CFS agencies, an assessment of what training and supervision currently is offered experienced MFT staff in CFS agencies would be useful in order to determine the realm of staff

needs for continuing training and supervision.

Statement of the Problem

The problem of this study was to investigate and describe the continuing needs for supervision and training that exist for marriage and family therapists in accredited child and family service agencies throughout the United States. Other key questions to be answered were:

1. Is there a diversity of therapy models used by supervisors with staff therapists in accredited child and family services agencies?
2. Of those staff practicing marriage and family therapy, how many have received post-graduate training from a recognized family therapy training center and/or have attained Clinical Member¹ status

¹Clinical Membership in the American Association for Marriage and Family Therapy (AAMFT) is awarded therapists who apply for such after completing over 1,500 clinical hours of marriage and family therapy. These 1,500 hours must have occurred while under the supervision of an AAMFT-Approved Supervisor. At least 200 hours of supervision must have occurred during this time period with the Approved Supervisor. Supervisors may work in clinics, agencies, private practice, universities, or hospital settings. This apprenticeship model of training has been utilized by thousands of therapists. It permits flexibility of scheduling and time commitment by supervisees.

The attainment of Clinical Member status occurs after one completes graduate training in an academic setting which teaches MFT curricula, followed by the clinical practice and supervision. The total process of supervision usually takes two to three years. Comparatively speaking, a training certificate from a free-standing family therapy institute may witness to one to three years of supervision and practice while attending the institute on a weekly basis.

in the American Association for Marriage and Family Therapy?

3. Do staff providing marriage and family therapy receive ongoing supervision, consultation, or training in marriage and family therapy?
4. How do supervisors monitor a staff therapist's changing needs for ongoing training?
5. Is there an actual model applied for MFT supervision and training used in CFS agencies for employed staff therapists?

Purpose of the Study

It was hoped that the results of this study would establish a direction for the eventual development of a marriage and family therapy training and supervision model that can be utilized by child and family service agencies with staff therapists.

Definitions and Abbreviations

Because the field of study for this paper is relatively limited, it was important that terms and concepts used were clearly defined. Any abbreviations used also were defined.

MFT. The abbreviation MFT is used for marriage and family therapy. Marriage and family therapy is defined as a therapeutic orientation and methodology that views problems for individuals being maintained or sustained by relationship difficulties. The etiology of problems

(especially of organic origins) may not be due solely to a relationship, per se, but how problems or symptoms are coped with depends upon the system of relationship interaction. A marriage and family therapist is concerned with the interactional variables between individuals as much as the internal system of the symptomatic person. The "client" is seen not as the person, but the system of persons that interact vis-a-vis the symptom or problem (e.g., a depressed wife is not the client, she and her husband as a marital unit comprise the "client" for treatment of the depression. Their interaction may be vital to the maintenance of the depressed behavior of the wife.).

There are several theories of MFT, but all hold allegiance to the unit of treatment being more than the individual, even though one or more persons may be seen for treatment at any given time.

Consultation. Consultation refers to the process whereby an experienced therapist (consultant) teaches a less-experienced therapist, or group of therapists, regarding improvement of their clinical skills. The consultant is not on the same agency staff as the less-experienced therapists.

Training. Training refers to one-time teaching experiences, or a series of teaching experiences, done under a planned, time-limited contractual agreement between an experienced therapist (trainer) and less-experienced

therapists.

Supervision. There are many definitions ascribed to supervision in the literature. Its meaning in this study is the overall process whereby an experienced therapist (serving as supervisor) enables a less-experienced therapist (trainee, supervisee, student) to acquire positive therapeutic behaviors and skills. It presupposes a supervisor contract for learning sequences and a time frame. The supervisor and supervisee(s) oftentimes are employed in the same agency setting.

Live Supervision. This term refers to the specific aspect of supervision whereby the supervisor watches the supervisee conduct a client session through either a one-way mirror or a closed-circuit television monitor from a room adjacent to the therapy room. Telephone interventions by the supervisor to the supervisee/therapist during the actual session may be to impart a therapeutic instruction about the session's progress, or to request that the supervisee/therapist leave the session and come discuss the session's progress with the supervisor.

Delayed Supervision. This term refers to the review session between supervisor and supervisee (may be one-to-one supervision or in a small group of supervisees with the supervisor) following the actual session with the client(s). Usually a review of an audiotape or videotape of the therapy session will be one of the primary foci of the

delayed supervision session.

Peer Consultation. This term refers to the formal, or informal, process of reviewing a clinical case's progress (with or without the playback of the session's audio-videotape) by therapists of equivalent experience levels on staff together in an agency. This would not include the supervisor in the process. A supervisor might engage in peer consultation with other clinical supervisors.

CFS. This abbreviation refers to child and family service agencies accredited by the Council on Accreditation of Services for Families and Children. The Council, as it is called, is the review body for maintenance of service standards in the following sponsor agencies: Family Service Association of America, Child Welfare League of America, Association of Jewish Family and Children's Agencies, Lutheran Social Service Systems, and National Conference of Catholic Charities.

Assumptions

Assumptions held by the author include the notion that marriage and family therapy training and supervision occurs regularly in CFS agencies for staff therapists. It is also assumed that supervision and ongoing training is desired by marriage and family therapy staff in CFS agencies.

Limitations

The results of this study are limited to the responses received from agency staff selected by CFS agency directors. The agencies contacted were randomly chosen from a total population of 296 CFS agencies which have Family Counseling Programs.

Delimitations

The delimitations of this study include that the population surveyed was chosen by the author as a random sample of CFS agencies with accredited Family Counseling Programs. Also, the nature of the questionnaire used was designed by the author.

Summary

Empirically sound theories of supervision have not yet been developed. There have been some efforts to establish models of MFT supervision and training which hold up to scrutiny, but these models have been proven effective only within the training centers where the models were actually developed.¹ As training and supervision efforts in

¹M. Andolfi and P. Menghi, "A Model for Training in Family Therapy," in Dimensions of Family Therapy, eds. I. Zwerling and M. Andolfi (New York: Guilford, 1980), pp. 239-60; D. C. Breunlin, R. C. Schwartz, M. S. Krause, and L. M. Selby, "Evaluating Family Therapy Training: The Development of an Instrument," Journal of Marital and Family Therapy, 9 (1983), 37-47; J. Byles, D. Bishop, and D. Horn, "Evaluation of a Family Therapy Training Program," Journal of Marriage and Family Therapy, 9, No. 3 (1983), 299-304;

MFT advance during this decade with the sophistication of MFT methodology, there will undoubtedly emerge training models which will stand the test of research for both their effectiveness and their diverse applicability in various settings.

The purpose of this study was to investigate the nature of ongoing needs by established MFT staff in CFS agencies for supervision and training. The compilation of this information helps to elucidate variables which a training and supervision model in MFT should address for experienced MFT who have completed their pre-employment clinical training.

J. Cleghorn and S. Levin, "Training Family Therapists by Setting Learning Objectives," American Journal of Orthopsychiatry, 43 (1973), 439-46; C. Falicov, J. Constantine and D. Breunlin, "Teaching Family Therapy: A Program Based on Training Objectives," Journal of Marital and Family Therapy, 7 (1981), 497-506; Liddle and Saba, pp. 63-72; K. Tomm and L. Wright, "Training in Family Therapy: Perceptual, Conceptual, and Executive Skills," Family Process, 18 (1979), 227-50; Tomm and Wright, "Multilevel Training and Supervision in an Outpatient Service Program," pp. 211-28.

CHAPTER TWO

Literature Review

The topics of supervision and training have been studied extensively in the mental health literature. Perhaps it is the diverse nature of these topics which has contributed to the range of writings to be found. Limited empirical research investigations are numerous, but these are far outnumbered by authors' personal speculations and notions about supervision and training. Writing about the application of a supervision theory appears to be far easier than testing the efficiency of a program or conceptual approach to training or supervision. Nowhere else is this perhaps more true than in the specific field of marriage and family therapy. In this review of the literature the primary emphasis will be on the writings which pertain directly to MFT supervision and training. Other sources regarding models of MFT, agency staff training needs in MFT, supervision and training in other psychotherapy orientations, and MFT research will be referred to as they impact specifically in the area of this study.

In reviewing the literature this chapter will be subdivided and organized as follows. First, the literature on the nature of the MFT training formats, contexts, and

methods will be reviewed. Next, the nature of MFT supervision formats and methods will be examined in the literature. The particulars and operating frameworks for MFT supervision, rather than training programs, will constitute the essence of this section in the review. Third, the area of research and evaluation of MFT training and supervision will be analyzed for important considerations regarding therapist learning needs and methods used to address those needs. Finally, the efforts at and writings about training and supervision programming for agency MFT staff will be studied. A summary of the literature review will conclude this chapter.

MFT Training - Formats and Methods

Training in MFT has been provided in a variety of different contexts and styles. Most often training encompasses a mixture of didactic and experiential teaching. Training does not presuppose a one-to-one teaching relationship, whereas clinical supervision, especially in a delayed modality, is frequently done in a one-to-one relationship.¹ Training is usually provided for groups of trainees possessing a variety of experience levels. In this literature review the scope of training programs and methods will be studied. While some of the training methodologies referred to are also used as part of

¹Kaslow, pp. 199-234.

a supervisory experience, a distinction will exist in this section that sets training programs and courses apart from the more personally intense, ongoing supervisor-supervisee relationships addressed in the second section of this review.

In a recent article by Simon and Brewster, the authors reviewed the nature of MFT training and its effects upon the trainee. They spoke of the serious difficulty trainees have when confronted with the emotional demands to rethink in terms of systems theory and family dynamics. Simon and Brewster point out correctly the dilemmas that already experienced therapists/counselors have to endure when forced to question the veracity of individually-oriented therapy and change models. Interviewing families or a large number of related individuals at the same time frequently terrifies therapists experienced with one person interviews. The authors imply that this learning process may be more difficult for experienced individually-oriented therapists than for the novice therapist. Helping trainees overcome this "frozen state" oftentimes becomes inherent in the training process of many training programs.¹

Liddle and Halpin made the first significant effort to review the literature and models for MFT training. They found that theories of supervision (and training) had not

¹R. Simon and F. Brewster, "What is Training?" The Family Therapy Networker, 7, No. 2 (1983), 24-49.

yet crystallized into formal constructs.¹ While recent publications have documented improvements in supervision theory construction,² much of what Liddle and Halpin discovered still holds true today. They noted that most of the literature is fragmented. As a result, the goals of training and the skills of the trainer/supervisor have been often dependent upon the theoretical orientation of the trainer or the particular training program. With the lack of theoretical integrity in a training program, or a clear model of training/supervision, the prospects of instilling panic and confusion into trainees during their rethinking process increases. Many authors besides Liddle and Halpin have argued for the need to keep clarity in the training approach.³ In fact, Kolevzon and Green's study, conducted in 1981 with graduates who had been intensively training in either the Bowen communications or strategic models of family therapy, supports formal and intensive training for

¹Liddle and Halpin, "Family Therapy Training and Supervision Literature: A Comparative Review," pp. 77-90.

²Whiffen and Byng-Hall, pp. 153-210.

³S. Stier and I. Goldberg, "Training Issues in Family Therapy," Journal of Marriage and Family Counseling, 1 (1975), 63-68; H. Liddle, "On the Problems of Eclecticism: A Call for Epistemologic Clarification and Human Scale Theories," Family Process, 21 (1982), 243-49; M. Kolevzon and R. Green, "Practice and Training in Family Therapy: A Known Group Study," Family Process, 22 (1983), 179-90.

developing adherents of a particular model. The study also advocated clearly that the distinctiveness of each MFT model needs to be more fully developed in preference to any premature attempts to develop generic or inclusive models that may become internally inconsistent and, therefore, difficult to operationalize in practice. If a therapy model is difficult to implement, it may be, therefore, due to the eclecticism attempts of the MFT trainer.

As with MFT, or any form of psychotherapy for that matter, there should be clear goals for the therapy process. Similarly, good training involves the setting of clear, attainable goals for developing therapist behaviors. The goals of training and supervision, Liddle and Halpin concluded, are dependent upon the theoretical assumptions and orientation of the trainer/supervisor.¹ These goals range from an emphasis on the personal growth of the trainee (e.g., family of origin work), to skills-focused objectives and goals (e.g., specified changes in the client system).

In the past ten years the McMaster University Medical School faculty have spearheaded a move to develop competency-based training programs. Cleghorn and Levin described a training program planned to teach trainees the

¹Liddle and Halpin, "Family Therapy Training and Supervision Literature: A Comparative Review," pp. 77-90.

necessary skills to conduct short-term, problem-focused MFT.¹ The work of Cleghorn and Levin at McMaster University was continued by Tomm and Wright at the University of Calgary Medical School.²

Tomm and Wright advanced the training program set forth by Cleghorn and Levin. Their training objectives were divided into three categories which were to be studied in sequential progression by trainees: perceptual (observational) skills, conceptual skills (translate observations into meaningful therapeutic language) and executive skills (therapeutic interventions made after understanding what has been observed). Examples of perceptual and conceptual skills that were given included recognizing and describing interactions, describing a family systemically, and recognizing one's idiosyncratic reactions to family members. The executive skills include developing a collaborative working relationship with the family, establishing the therapeutic contract, and taking control of maladaptive transactions.

While the accounts of this training program are not substantive research studies, the foundation of the McMaster MFT model itself has been researched. Using the Family

¹Cleghorn and Levin, pp. 439-46; N. B. Epstein and D. S. Bishop, "Problem-centered Systems Therapy of the Family," in Handbook of Family Therapy, eds. Alan S. Gurman and David P. Kniskern (New York: Brunner/Mazel, 1981).

²Tomm and Wright, pp. 227-50.

Categories Schema, the McMaster group have systematized a way of classifying and observing family behavior, generated research on the predictability of family therapist behavior, and developed the consistent theoretical and practical implementation of a well-defined model of training.¹

The objectives of training, behavioral skills, and evaluation criteria have been pinpointed for teaching particular models of therapy. This teaching occurs in various contexts, including freestanding institutes,² state-sponsored agencies,³ and academic settings.⁴ Garrigan and Bambrick completed a four-year outcome research and training project at the Centennial School of Lehigh University which drew significant conclusions regarding the training of family therapists, thereby greatly influencing the operations of training contexts today.⁵ These authors operationally defined the major constructs and therapist competencies of Zuk's "go-between" method of family therapy. They asserted ". . . that learning objectives and expectations be specified in empirical terms so that trainer

¹Epstein and Bishop, pp. 444-82.

²Berman and Dixon-Murphy, pp. 77-82.

³Falicov, Constantine and Breunlin, pp. 497-506.

⁴Stanton, pp. 433-39.

⁵J. G. Garrigan and A. F. Bambrick, "Introducing Novice Therapists to the 'Go-Between' Techniques of Family Therapy," Family Process, 16 (1977), 237-46.

trainee can achieve clear goals, identify areas of progress, and meet the special needs of the trainee."¹ Most recently, the work of Liddle and Saba and Falicov, Constantine and Breunlin have further documented the benefits derived from clearly defined objectives being established initially for any MFT training program or coursework.²

Similarly, two behaviorally-oriented psychologists at the University of Utah have established sets of therapist skills.³ These authors refer to their MFT model as Functional Family Therapy. They have broadened and defined the classes of skills usually associated with social learning or behavioral family therapy models. Barton and Alexander researched the kinds of therapist behavior related to positive therapy outcome. They suggest that good training should not only entail technical and conceptual competencies but also include flexible interpersonal skills. Referring to this latter set of behaviors, Barton and Alexander asserted that this stylistic dimension is the primary behavioral set upon which relationship and

¹Garrigan and Bambrick, p. 237.

²Liddle and Saba, pp. 63-72; Falicov, Constantine and Breunlin, pp. 497-506.

³C. Barton and J. Alexander, "Therapists' Skills as Determinants of Effective Systems-Behavioral Family Therapy," International Journal of Family Counseling, 5 (1977), 11-20; C. Barton and J. F. Alexander, "Functional Family Therapy," in Handbook of Family Therapy, eds. A. S. Gurman and D. P. Kniskern (New York: Brunner/Mazel, 1981), 403-43.

techniques and structuring skills depend.

The Structural school of MFT has also been known for advocating the teaching of family therapy in a competency-based and skills-focused manner.¹ Training contexts, such as the Philadelphia Child Guidance Clinic, advocate the usage of training techniques which facilitate behavioral changes by the therapist designed to create structural changes in dysfunctional family systems. Montalvo addressed training skills and goals from the perspective of one utilizing a live supervisory model.² This training model parallels the principles inherent in the structural approach by directly providing corrective feedback to the therapist/trainee simultaneous to the therapy session. According to this approach, the training task is to prevent the therapist/trainee from being ensnarled in unproductive patterns with the family.³ The usage of this training technique as a supervision technique or methodology takes on even more complex meaning as will be discussed later in this

¹H. J. Aponte and J. M. VanDeusen, "Structural Family Therapy," in Handbook of Family Therapy, eds. A. S. Gurman and D. P. Kniskern (New York: Brunner/Mazel, 1981), pp. 310-60.

²B. Montalvo, "Aspects of Live Supervision," Family Process, 12 (1973), 343-59.

³E. Coppersmith, "Expanding Uses of the Telephone in Family Therapy," Family Process, 19, No. 4 (1980), 411-17; G. Birchler, "Live Supervision and Instant Feedback in Marriage and Family Therapy," Journal of Marriage and Family Counseling, 1 (1975), 331-42.

review. As part of a time-limited training program there is less emotional variance in its effectiveness than possibly so as part of an ongoing supervisory relationship.¹

The Structural and Behavioral schools of MFT have modeled the teaching acumen of several noted training programs, perhaps due to the emphasis upon clearly-taught objectives for MFT trainees. Andolfi and Menghi, trained here in the United States at the Philadelphia Child Guidance Clinic, have developed a pioneering training program in Rome, Italy, which has trained scores of therapists from central and southern Europe in basic MFT skills.² Skynner and Skynner document a similarly effective program at the Tavistock Clinic in London, England, which uses an integrative systems-psychoanalytic approach to teaching MFT.³ Their program parallels that developed by Rosenbaum and Serrano in the style of teaching systems thinking to trainees, regardless of the orthodoxy of their particular trainers to certain "schools" of MFT.⁴ This later program was developed on two simultaneous settings, academic

¹M. Berger and C. Damman, "Live Supervision as Context, Treatment and Training," Family Process, 21 (1982), 337-44; R. Beroza, "The Shoemaker's Children," The Family Therapy Networker, 7, No. 2 (1983), 31.

²Andolfi and Menghi, pp. 239-60.

³A. R. Skynner and P. Skynner, "An Open-Systems Approach to Teaching Family Therapy," Journal of Marital and Family Therapy, 5, No. 4 (1979), 5-16.

⁴Rosenbaum and Serrano, pp. 77-82.

(University of Texas) and a child guidance clinic in the San Antonio area. Illustrative of many other MFT training programs housed as part of a medical school, the Hahnemann Medical College and Hospital in Philadelphia offers a highly-reputable masters-level academic program that accents clearly delineated skill objectives for trainees to attain. More so than most degree-granting programs, the Hahnemann program has been documented as being one of the most successful at training therapists in specific learned skills and behaviors for MFT, while still teaching all of the primary schools of thought in MFT.¹ This seems to be somewhat unusual as oftentimes the diverse focus of various theories dilutes the clear thinking and precision of trainees in therapy sessions.

As is more often found to be the case, Liddle and Halpin observed that as the theoretical orientation of trainers vary so, too, do the emphases of many training programs.² For example, the "Boston model" of MFT, taught at the free-standing institutes of the Boston Family Institute and the Cambridge Family Institute, represents an attempt to comprehensively define and describe an experientially-oriented philosophy of training which

¹Garfield, pp. 261-72.

²Liddle and Halpin, pp. 77-90.

de-emphasizes the learning strictly of techniques.¹ This model of MFT training, like the psychoanalytic MFT programs,² tends to stress the personal growth aspects of training and emotional lives of trainees in relation to their own families of origin. The uniform emphasis is on integrating cognitive and experiential learning styles. This is in direct variation from the programs operating more from Structural,³ Behavioral,⁴ and Strategic orientations wherein goals are cognitively-based and focus on defining therapist skills rather than the therapist's personal development.⁵

The theoretical orientation of the particular training program therefore can have significant implications for how researchable the therapy methodology and training format

¹L. Constantine, "Designed Experience: A Multiple, Goal-Directed Training Program in Family Therapy," Family Process, 15, No. 4 (1976), 389-96; Duhl and Duhl, pp. 59-76.

²LaPerriere, pp. 53-58; J. L. Framo, "A Personal Viewpoint on Training in Marital and Family Therapy," Professional Psychology, 10 (1979), 868-75.

³Aponte and VanDeusen, pp. 310-60.

⁴Cleghorn and Levin, pp. 439-46; Epstein and Bishop, pp. 444-82.

⁵J. Haley, "Problems in Training Therapists," in Problem Solving Therapy, ed. J. Haley (San Francisco: Jossey-Bass, 1976), pp. 169-94; J. Haley, "Ideas that have Handicapped Therapists," in Leaving Home, ed. J. Haley (New York: McGraw-Hill, 1980), pp. 9-25; J. Haley, "A Quiz for Young Therapists," in Reflections on Therapy and Other Essays, ed. J. Haley (Chevy Chase, MD: Family Therapy Institute, 1981), pp. 237-43.

is. This is especially true in free-standing institutes which may advocate the learning of a particular MFT model to the exclusion of other models. In spite of the variation in training and therapy models, from the focus being upon therapist skill development to therapist personal development, there is a trend in the literature to establish clearly defined therapist competencies, even though it is still done according to the differing schools of MFT thought.

Each of the programs reviewed thus far have been clearly training programs. These are time-limited, with several trainees working with a few trainers over a period of six months to two years. Especially in the non-academic settings, this training does not occur daily throughout the time frame. More often the case is that trainees attend one to three days a week. The trainee is part of a class, with less emphasis placed upon the trainer-trainee relationship than might normally be found in the supervisor-supervisee relationship found in agencies and mental health centers on an intensive, daily basis.

MFT Supervision: Formats and Methods

Supervision has been researched and studied widely in fields of psychotherapy such as MFT. Several perspectives exist on the topic of how to supervise MFT supervisees most effectively. Leddick and Bernard reviewed the history of supervision and noted that there certainly has been a lack

of theoretical base for supervision.¹ They found that supervision, as with training, is linked to the assumptions and theoretical bases of one's counseling/therapy practice. Likewise, supervision has evolved with the change in different therapeutic approaches. Nowhere is this more true than in MFT. Kniskern and Gurman pointed out also that in family therapy theoretical orientation influences the focus on supervision.² A Behavioral, Structural, or Strategic approach by a supervisor will almost exclusively focus on the difficulties of the family being treated, while a supervisor from Psychoanalytic, Transgenerational, or Symbolic Experiential MFT theory focus almost totally on the therapist, independent of the family case.³ Abrams coined the term "metatherapy" to describe the latter supervision format.⁴

Regardless of the theoretical orientation of the supervisor it has been claimed that a parallel process

¹G. Leddick and J. Bernard, "History of Supervision: A Critical Review," Counselor Education and Supervision, 19 (1980), 186-96.

²Kniskern and Gurman, "Research and Training in Marriage and Family Therapy," pp. 221-38.

³C. A. Whitaker and D. V. Keith, "Symbolic-Experiential Family Therapy," in Handbook of Family Therapy, eds. A. S. Gurman and D. P. Kniskern (New York: Brunner/Mazel, 1981), pp. 187-225.

⁴G. Abrams, "Supervision as Metatherapy," in Supervision, Consultation, and Staff Training in the Helping Professions, ed. F. Kaslow (San Francisco: Jossey-Bass, 1977), pp. 81-99.

occurs between supervisor and supervisee in their working relationship.¹ As there may be stress points or impasses between the therapist/supervisee and the client system, Doehrman documented that a parallel dynamic simultaneously occurs in the supervisory relationship. Once clarity is re-established in the supervisory relationship, then the therapeutic system regains its direction. The ability of the supervisor to maintain a clear focus in the supervisory process depends upon the experience of the supervisor as well as the repertoire of supervisory skills possessed by the supervisor.

Mendelsohn and Ferber, representatives of the Symbolic-Experiential school of MFT, have enumerated a number of supervisory skills.² These skills, such as live observation, are also primary skills used by other MFT schools for supervision, even though the focus for change by Mendelsohn and Ferber is the therapist's cognitive behavior. They note a solid intellectual grasp of the field, ability to continue to learn as one teaches and supervises, the capacity to control supervisory process whether in one-to-one sessions or group supervision, and a

¹M. Doehrman, "Parallel Processes in Supervision and Psychotherapy," Bulletin Menninger Clinic, 40, No. 1 (1976), 3-84.

²M. Mendelsohn and R. Ferber, "Training Program," in The Book of Family Therapy, eds. A. Ferber, M. Mendelsohn and A. Napier (Boston: Houghton-Mifflin, 1973), 239-71.

high level of clinical expertise as some of these desirable supervisory behaviors. This latter skill, therapeutic competence, is primary to their particular MFT approach since the supervisor is relied upon as a positive role model for supervisees. They also underscored the need for the supervisor to be free to select a comfortable style or format for supervision. The terms of this contract should be negotiated with the supervisee. Mendelsohn and Ferber used supervisory methods ranging from the traditional format of discussing a supervisee's verbal report of a session to observation of the supervisee's therapy session live or via videotape playback.¹ They also were open to the sitting-in supervisor approach or as an active co-therapist.²

The degree to which the supervisory contract is clear to both supervisor and supervisee is nowhere stressed more than by the advocates of live supervision. In this supervisory format the supervisor, more than observing the session live, actively intervenes in the therapy session. Trust in the supervisory relationship is imperative. In this supervisory model the supervisor can actively guide

¹S. Kempster and E. Savitsky, "Training Family Therapists through Live Supervision," in Expanding Theory and Practice in Family Therapy, ed. N. Ackerman (New York: Family Service Association of America, 1967), pp. 125-34.

²A. Napier and C. Whitaker, "Problems of the Beginning Family Therapist," in Techniques of Family Psychotherapy: A Primer, ed. D. Block (New York: Green and Stratton, 1973), pp. 109-22.

the therapist during a session by providing corrective feedback through telephone communication between the consultation and observation rooms. The supervisor can interrupt the session to direct the supervisee's actions at the moment the behavior is occurring. Montalvo asserted that "the most basic assumption of all is that any family can absorb and orient the therapist and direct him away from his function as a change agent."¹

Ground rules for conducting live supervision should be adopted, according to Montalvo, Haley and Heath.² When the supervisor will be calling, what will be discussed when the supervisor calls, when the supervisee may come out for feedback or discussion are key points for clarification before the initial therapy interview. Montalvo admonished that communication problems in the supervisory relationship influence the therapy outcome. Gershenson and Cohen wrote a convincing account of being supervisees using this supervisory format.³ Their experiences underscore Montalvo's concerns.

¹Montalvo, p. 345.

²Montalvo, pp. 343-59; Haley, "Problems in Training Therapists," pp. 169-94; A. Heath, "The Live Supervision Form: Structure and Theory for Assessment in Live Supervision," in Diagnosis and Assessment in Family Therapy, ed. B. Keeney (Rockville, MD: Aspen Systems Corporation, 1983), pp. 143-55.

³J. Gershenson and M. Cohen, "Through the Looking Glass: The Experiences of Two Family Therapy Trainees with Live Supervision," Family Process, 17, No. 2 (1978), 225-30.

Good supervision includes the teaching of ongoing assessment and diagnostics as part of implementing a treatment plan. Heath's live supervision form helps both supervisor and supervisee prepare effectively for the next live supervision session.¹ Furniss, Bentovim, and Kinston developed a new use for the traditional social work supervision technique of process recordings.² They effectively demonstrated how, in post-session review, the supervisee can show his/her degree of learning in assessment skills by documenting alongside the transcription exactly what dynamically was occurring in the session at that moment. This editing of the process recording allowed the supervisor an opportunity to review the supervisee's actual understanding of the dynamics in the therapeutic system. A similar teaching tool, the "Family Floor Plan," has been implemented also for ongoing assessment purposes by Coppersmith and other of her supervisors.³

Most recently in the literature there has been attention given to the question of how supervisors

¹Heath, "The Live Supervision Form: Structure and Theory for Assessment in Live Supervision," pp. 143-55.

²T. Furniss, A. Bentovim and W. Kinston, "Clinical Process Recording in Focal Family Therapy," Journal of Marital and Family Therapy, 9, No. 2 (1983), 147-70.

³E. Coppersmith, "The Family Floor Plan: A Tool for Training, Assessment and Intervention in Family Therapy," Journal of Marital and Family Therapy, 6, No. 2 (1980), 141-44.

learn to become supervisors. This issue parallels the focus made by many researchers and authors on developmental stages in the supervision of therapists. Akin and Weil reviewed how supervisors learn to become supervisors in the child welfare system, without specific attention to therapy supervision.¹ They observed that supervisors became supervisors normally after they had attained a stage of competency (or seniority) which surpassed all other similar staff in a particular service agency. Similarly, in regard to MFT supervision, Heath and Storm pleaded for the development of systematic training for supervisors.² They noted that people oftentimes become supervisors through default more than design. Training for supervisors in MFT might be likened to training for counselors and therapists in that developmental stages seem to exist based upon competency and experience.

Developmental stages of supervision for therapists have been studied and researched in recent years. Ekstein and Wallerstein were among the earliest authors to attend to supervision stages and raise the issue of a developmental

¹G. Akin and M. Weil, "The Prior Question: How do Supervisors Learn to Supervise?" Social Casework, 62, No. 8 (1981), 472-79.

²A. Heath and C. Storm, "Answering the Call: A Manual for Beginning Supervisors," The Family Therapy Networker, 7, No. 2 (1983), 36-39.

process for therapists.¹ They noted those phases namely, the "beginning" phase, the "learning process" phase, and the "end" phase. The beginning phase is primarily a time when the supervisee develops a relationship with the supervisor which is conducive to learning. Actual learning, rather than metatherapy occurs at this time.² The learning process phase is characterized by interpersonal conflicts and the working through of these conflicts in the supervisor-supervisee relationship. During this stage the supervisor is seen by Ekstein and Wallerstein to be in the role of counselor-teacher with the supervisee. The end phase is characterized by encouragement of supervisee autonomy. The supervisor moves from being the active teacher to a less active, autonomy-encouraging collegial role. This model closely parallels the writings of Littrell, Lee-Broden, and Lorenz.³

While advocating a developmental framework for counseling supervision, Littrell et al. criticized advocates of supervision as either teaching or

¹R. Ekstein and R. Wallerstein, The Teaching and Learning of Psychotherapy, 2nd ed. (New York: International Universities Press, 1972).

²Abrams, pp. 81-99.

³J. Littrell, N. Lee-Broden and J. Lorenz, "Developmental Framework for Counseling Supervision," Counselor Education and Supervision, 18 (1979), 129-36.

metatherapy.¹ They felt that those advocates tended to wrongly assert that their chosen model adequately describes the complete process of supervision. Using a framework similar to that of Ekstein and Wallerstein,² the authors pointed out that all supervision models are necessary. Their framework for using different models consisted of three stages: Stage I was the working relationship, involving contract setting; Stage II incorporated both teaching and counselor roles by the supervisor; and Stage III characterized the relationship as being one of consultation.

There has been much documented in the literature of traditional psychotherapy which parallel the work of Ekstein and Wallerstein and Littrell et al.³ In a recent dissertation studying the process variables inherent in a developmental perspective for supervision, Kersey underwent an extensive study of developmental supervision literature.⁴ He discovered that very little in the literature was founded upon actual research studies. However, Kersey employed some of the notions of

¹Littrell et al., pp. 129-36.

²Ekstein and Wallerstein, pp. 89-111.

³Ekstein and Wallerstein, pp. 89-111; Littrell et al., pp. 129-36.

⁴Kersey, "Supervisory Process and Focus Applied in the Development and Training of Marriage and Family Therapists," pp. 23-43.

supervision as a developmental model with conceptualized change points for the supervisee in his content analysis of supervisor behaviors with beginning or advanced supervisees.¹ The use of content analysis was not new for Kersey but few in the MFT field have paralleled the efforts he made to study the actual content and developmental stages for MFT supervision.² The work of Fisher and Embree is the only other representation of this type of effort. They developed the supervision Coding System, an observational scheme designed to assess the specific topic areas addressed during the course of supervisory session. They studied both the focus (content or topic) and process (relationship interaction) in supervision.³

Other recent articles expound the necessity of approaching supervision from a developmental skills perspective but they do not have research built into their analysis. As with most all work in the area of supervision, for traditional psychotherapy or MFT, most of what has been written has been the expounding of the authors about what they think supervision should be like based on their

¹C. Loganbill, E. Harding and V. Delworth, "Supervision: A Conceptual Model," The Counseling Psychologist, 10, No. 1 (1982), 3-42.

²G. H. Allred and F. L. Kersey, "The AIAC, a Design for Systematically Analyzing Marriage and Family Counseling: A Progress Report," Journal of Marriage and Family Counseling, 3 (1977), 17-25.

³Fisher and Embree, n.p.

experience.¹ The writings in the area of MFT supervision rarely advocate for a developmental approach.² Usually what has been written in MFT supervision is offered by proponents of a particular MFT model.

As a summary thus far, the existing material on the definition and task of the supervisor-supervisee relationship reflects a heterogeneity similar to where the MFT literature on techniques and methods of supervision is currently. There appears to be a continuum which has emerged in the supervision literature, especially as found in the MFT field. Some believe in an equal, personal, and more process-focused definition for supervision, while at the opposite end a task, skills, and goal-oriented philosophy exists refuting the assumption that a collegial structure to any supervision relationship is possible. Finally, there are those who have defined the relationship in developmental terms. From this perspective the early phases of the relationship are viewed from a structuralistic perspective while the later stages are thought to develop along more collegial, egalitarian characteristics.

¹C. Stoltenberg, "Approaching Supervision from a Developmental Perspective: The Counselor Complexity Model," Journal of Counseling Psychology, 28 (1981), 59-65; D. L. Sansbury, "Developmental Supervision from a Skills Perspective," The Counseling Psychologist, 10, No. 1 (1982), 53-58.

²B. Tucker, G. Hart and H. Liddle, "Supervision in Family Therapy: A Developmental Perspective," Journal of Marriage and Family Counseling, 2, No. 3 (1976), 260-76.

Research and Evaluation of MFT Training
and Supervision

Not only have supervision and training for the field lagged behind the pace of MFT development itself, but very little research has been completed even for MFT supervision and training. The observations of Liddle and Halpin seem to ring true yet:

the slow rate of progress in training program evaluation is partially due to the complexity of this area. Training programs are rarely fully described in terms of objectives, content, and process, making replicability difficult. Further, the wide variability of training contexts similarly makes replication of successful programs a complex task.¹

One of the pitfalls in developing training and supervision programs for marriage and family therapy stems from the difficult issue of replication procedures. The family therapy field has early been advanced through the work of many charismatic leaders such as Satir, Minuchin, Jackson, Haley, and Ackerman. The training in the field which furthers the work of these masters must be now conducted with an evaluative component. Trainers who have rigorously endeavored in the evaluation area have focused on the systematization of their programs' objectives.²

¹Liddle and Halpin, p. 88.

²Barton and Alexander, "Therapists' Skills as Determinants of Effective Systems-behavioral Family Therapy," pp. 11-20; Barton and Alexander, "Functional Family Therapy," pp. 403-43; Constantine, pp. 389-96; Cleghorn and Levin, pp. 439-46; Garrigan and Bambrick, pp. 237-46; Tomm and Wright, "Training in Family Therapy:

Evaluation and research on the specification of therapist behaviors has been a necessary step in training research. Barton and Alexander performed some of the earliest research into the area of important learned therapist skills in marriage and family therapy.¹ Their Functional family therapy (behavioral-systems) model was easily researchable, with its emphasis upon observable and specific change objectives in MFT. Their results found that improvement in therapist technique repertoire and intervention skills positively affected outcome with families. However, of perhaps even more importance was the therapist's array of personal interactional skills. The therapist skill of empathy proved to be highly important. More than the variation in technique knowledge, the interpersonal skills (empathy, warmth, etc.) had the greatest impact on therapy outcome.

In a similar study, Gurman and Kniskern analyzed the factors which contribute to deterioration in marriage and

Perceptual, Conceptual, and Executive Skills," pp. 227-50; Tomm and Wright, "Multilevel Training and Supervision in an Outpatient Service Program," pp. 211-28; K. Tomm and M. Leahey, "Training in Family Assessment: A Comparison of Three Methods," Journal of Marital and Family Therapy, 6 (1980), 453-59.

¹Barton and Alexander, "Therapists' Skills as Determinants of Effective Systems-behavioral Family Therapy," pp. 11-20.

family therapy.¹ They found two significant variables which contributed greatly to therapy regression and failure. In order of importance, these variables were poor therapist relationship skills and technique deficiencies. Gurman and Kniskern have raised the concern for good screening of training applicants.² They contend that technique can be taught, but for some trainees learning relationship skills would be a prior consideration. This learning may be a part of their MFT training or through concurrent experiences (e.g., personal or family therapy).

Kniskern and Gurman have written extensively on the nature of MFT research and evaluation. Their aforementioned studies on therapist variables for effective marriage and family therapy have been significant in the field of MFT. Their more recent studies have delved into training research, rather than researching family therapy outcome. In support of Liddle and Halpin, Kniskern and Gurman found very little on the topic of research for family therapy training.³ They claimed that by comparison, "the paucity

¹A. S. Gurman and D. P. Kniskern, "Deterioration in Marital and Family Therapy: Empirical, Conceptual and Clinical Issues," Family Process, 17 (1978), 3-20.

²Ibid.; A. Gurman and D. Kniskern, "Family Therapy Outcome Research: Knowns and Unknowns," in Handbook of Family Therapy, eds. A. Gurman and D. Kniskern (New York: Brunner/Mazel, 1981), pp. 742-76.

³Liddle and Halpin, pp. 77-90; Kniskern and Gurman, "Research and Training in Marriage and Family Therapy," pp. 221-38.

of research investigating training in family therapy parallels the state of research on training in individual psychotherapy."¹ Kniskern and Gurman pointed to the soft underbelly of the family therapy field. "Family therapists are rarely trained in outcome evaluation skills concurrent with their clinical training."² The field has developed so rapidly that little planning has gone into the teaching of research skills for marriage and family therapists. Yet without such skills, training program staffs will continue to lack methods for evaluating the actual effectiveness of their programs. The authors contended that no training program can responsibly be said to be effective unless its graduates can demonstrate more positive effects and fewer negative results with the families they treat after receiving training than before receiving training.

Kniskern and Gurman raised key questions for researchers to investigate in marriage and family therapy training.³ They offered numerous questions about what types of training experiences are especially potent in producing effective therapists. Four primary areas for questions were outlined by Kniskern and Gurman: selection criteria of trainees; didactic methods used; supervision methodology in

¹Kniskern and Gurman, "Research and Training in Marriage and Family Therapy," p. 221.

²Ibid., p. 229.

³Ibid., pp. 221-38.

training programs; and types of experiential methods which best promote learning.¹

Beyond considering what experiences are most effective for quality family therapy training, Kniskern and Gurman addressed an aspect of training research not found in any other references investigated. They strongly recommended that assessment research allow for the possibility of detecting a worsening of some trainees' skills as the result of training. The evaluation of training for this knowledge base should be made from a number of perspectives and on several dimensions. The perspectives to be investigated might include those of trainees, supervisors, as well as independent judges of training programs. The dimensions of change measurement in trainees for positive or negative skill development would include: "his/her conceptual knowledge of families; trainee's in-therapy behavior; trainee's personal life; and outcomes of families treated by trainee."²

While Kniskern and Gurman are well-documented in the area of marriage and family therapy and training research, a less-known, yet important, article by Mead and Crane helped to lay the groundwork for some of the current research

¹Kniskern and Gurman, "Research and Training in Marriage and Family Therapy," p. 231.

²Ibid., p. 233.

studies in MFT training and supervision.¹ Mead and Crane wrote about a program of supervision implemented at Brigham Young University in Provo, Utah. Theirs was not an actual research study, as are most of the references thus far cited. Rather, their article documents what they refer to as "an empirical approach to supervision and training of marriage and family therapists."² Their focus assumed that supervisors should attend primarily to the behavior of therapists, with the goal of supervision to develop clinicians who can do marriage and family therapy independently. To this end, their program emphasizes that supervisors should be accountable for specific skill development in their trainees so that therapists can be prepared to be effective in many different situations.

Historically, supervisors have approached the task of supervision by training counselors in a given theoretical approach to therapy . . . In marriage and family counseling we have tended to emulate that same deductive approach to supervision and training, only with theoretical approaches developed for use with families such as systems, communications, and network theory. This approach has been helpful, but it has not produced rapid development of knowledge concerning the most effective and efficient ways to train marriage and family therapists. What is needed is a body of knowledge about how to supervise specific therapists, encountering specific types of problems, in specific settings, with specific clients encountering specific problems . . . The

¹E. Mead and D. Crane, "An Empirical Approach to Supervision and Training of Relationship Therapists," Journal of Marriage and Family Counseling, 4, No. 4 (1978), 67-76.

²Ibid., p. 67.

supervisor who wishes to help a trainee become more effective must observe him/her doing marriage and family counseling . . . Supervisors are acting in the clients' best interest when they observe the counselor's behavior, with the intention of helping the counselor to act in ways which will be more beneficial for the clients.¹

Mead and Crane see the advantages of using an empirical approach as being two-fold: it allows for a systematic investigation of the skills and competencies of the therapist; it also allows for establishing a basis for the scientific study of supervision with a clear statement of problems and methods for solutions to therapist skill development.² They devised what they referred to as the Counseling Problems Worksheet, a simple grid form which allows the pinpointing of skill deficits by supervisor and trainee/therapist following the review of a client session. They use their observational data to specify the problem behaviors which impede therapy progress and what can be done to correct the problem by supervisor and therapist/trainee alike. The progressive stages of observation, pinpointing the necessary skills development, hypothesis formation about how best to improve the therapist's skills, testing of the hypothesis by supervisory intervention, and evaluation of the intervention's effectiveness are viewed by Mead and Crane as paralleling

¹Mead and Crane, p. 68.

²Ibid., pp. 67-76.

the steps of classic scientific investigation. Their emphasis upon specifiable change and effectiveness in both the therapy and supervision is syntonic with the research work of Knistern and Gurman, Barton and Alexander, and Tomm and Wright.¹

In a similar vein, Woodward, Santa-Barbara, Levin and Epstein and Sprenkle and Fisher investigated empirical approaches to researching family therapy outcome.² These studies documented efforts at McMaster University and Purdue University, respectively, to elucidate factors which contribute to effective supervision of MFT.

Most recently, studies have built upon the questions raised by Kniskern and Gurman.³ Byles, Bishop and Horn evaluated the effectiveness of a training program provided

¹D. Knistern and A. Gurman, "Research on Training in Marriage and Family Therapy: Status, Issues, and Directions," Journal of Marital and Family Therapy, 5, No. 3 (1979), 83-94; Knistern and Gurman, "Research and Training in Marriage and Family Therapy," pp. 221-38; Barton and Alexander, "Therapists' Skills as Determinants of Effective Systems-Behavioral Family Therapy," pp. 11-20; Barton and Alexander, "Functional Family Therapy," pp. 403-43; Tomm and Wright, "Training in Family Therapy: Perceptual, Conceptual, and Executive Skills," pp. 227-50.

²C. A. Woodward, J. Santa-Barbara, S. Levin, and N. B. Epstein, "The Role of Goal Attainment Scaling in Evaluating Family Therapy Outcome," American Journal of Orthopsychiatry, 48 (1978), 464-76; D. Sprenkle and B. Fisher, "An Empirical Assessment of the Goals of Family Therapy," Journal of Marital and Family Therapy, 6 (1980), 131-40.

³Kniskern and Gurman, "Research and Training in Marriage and Family Therapy," pp. 221-38.

to twenty-five staff of the Catholic Charities Association in the Greater Buffalo, New York, area.¹ The training was provided by the family therapy program faculty at McMaster University. The trainees received a year-long training program, on-site in their agency. The trainees were all social workers with varying levels of academic education. All were agency staff unfamiliar with family therapy and family systems assessment methodology. They were taught the basics of the Problem-Centered Systems Family Therapy model developed over a decade ago at McMaster University by Epstein and Bishop. It is a brief therapy model requiring clear specification of the problems to be altered and contract development with the client family.

A simple pre- and post-test model was used by Byles et al. to test for conceptual knowledge improvement by agency staff.² Their goals included furthering the perceptual and cognitive abilities of the agency staff, many of whom did intend to continue as therapists within their respective agencies. The authors found that a distinctive improvement was made in the utilization of family systems thinking and case planning by trained staff. An increase in family therapy as a methodology was documented in each of the participating agencies several months following the

¹Byles et al., pp. 299-304.

²Ibid.

training program's completion. What this study most of all illustrated, though, was that a time-limited training program taught by non-agency staff trainers to staff of child welfare/family service agencies could be effective in altering the conceptual knowledge base for those staff to use in their therapy and case management.

The question of how best to teach trainees, either at an independent training institute, or in the actual service site of trainees, has been raised by Breunlin et al.¹ This staff, of the Institute for Juvenile Research in Chicago, Illinois, has developed an evaluation method and instrumentation which is designed to test for pre- and post-training program knowledge of trainees enrolled in their one-year family therapy externship program. The authors document the development and successful testing of a paper-and-pencil inventory which measures the conceptual, cognitive and skill application knowledge base of their trainees before and after the training program. By showing a videotape of a role-played family session, trainees are asked a series of closed- and open-ended questions which require the trainee to explain what is perceived in the session, how to explain the behavioral sequences in family therapy theoretical terms, what should be the treatment plan, how the plan should be implemented, and how will

¹Breunlin et al., pp. 37-47.

therapy be measured for effectiveness. The authors report that this form of testing has demonstrated conceptual knowledge improvement by trainees.

In all the studies thus far noted, authors have recommended either questions to be researched or methods that would test the effectiveness of training techniques to teach a knowledge base for marriage and family therapy. A virtual frontier yet exists to be researched, however, as only the tip of the training and supervision iceberg has been touched. Ultimately, sound experimental design research investigating many variables and therapy application effectiveness by trainees needs to be conducted. But as Kniskern and Gurman have already noted, unless research methods are made an integral part of any MFT training program, such research will remain a distant "luxury" consideration contrasted with the more exciting skills development found as the sole emphasis in training programs to date.¹

Training and Supervision Programming for Agency Therapists

Specific to the concerns of this paper are the attempts made thus far to provide training and supervision in marriage and family therapy to the staff of accredited child

¹Kniskern and Gurman, "Research and Training in Marriage and Family Therapy," pp. 221-38.

and family service agencies. A significant set of problems arise when this particular population of therapists is considered for training. Many mental health clinicians, whether as staff in clinics or family service agencies, wish to develop their MFT skills. But, as Markowski and Cain have noted regarding staff of mental health centers:

budget restrictions, time constraints and the location of major marital and family therapy training centers prevent many clinicians from developing these skills subsequent to graduate degree work. As a result mental health clinicians usually learn about marital and family therapy through personal reading, one or two day conferences or workshops, and trial and error practice. In those instances where a clinician does have the opportunity to participate in an out-of-center training program, it is usually specific in orientation. On returning to the mental health center, the clinician often lacks the support group needed for encouragement and further skill development. If there is an attempt to share a newly acquired approach with colleagues, the clinician must be prepared to deal with therapists vested in different and sometimes antagonistic conceptual orientations.¹

Efforts have been made to overcome the problems which Markowski and Cain have noted. Flomenhaft and Carter and Markowski and Cain developed structural family therapy training programs for staff of mental health centers.²

¹E. M. Markowski and H. I. Cain, "Live Marital and Family Therapy Supervision: A Model for Community Mental Health Centers," The Clinical Supervisor, 1, No. 3 (1983), 37-38.

²K. Flomenhaft and R. Carter, "Family Therapy Training: Program and Outcome," Family Process, 16 (1977), 211-18; E. M. Markowski and H. I. Cain, "Marital and Family Therapy Training and Supervision: A Regional Model for Rural Mental Health," The Clinical Supervisor, 1, No. 1 (1983), 65-75.

In each case preliminary support was necessary from both state and mental health center administrators before any success could be expected from these programs. Flomenhaft and Carter documented the results of a four-year-old training program conducted for staff of mental health centers located throughout Pennsylvania.¹ The trainers were from the Philadelphia Child Guidance Clinic. Each trainer would travel weekly to sites in rural Pennsylvania (mental health centers) to provide live supervision of beginning family therapy skills for staffs of those centers. In all, 300 practitioners received their initial training through this program. Additionally, a core group of sixty-four family therapy trainers was developed. The strongest effect of the program reported was an increase in the participants' use of family therapy. Prior to the program the mean percent of time spent seeing families in therapy was 14.4 percent, while after it was 39.31 percent.²

As in the Flomenhaft and Carter study, Markowski and Cain attempted to provide a conceptual framework for assessment and treatment that could be readily integrated into the day-to-day functioning of the clinician.³

¹Flomenhaft and Carter, pp. 211-18.

²Ibid., p. 212.

³Markowski and Cain, "Marital and Family Therapy Training and Supervision: A Regional Model for Rural Mental Health," pp. 65-75.

Their training program was developed in rural North Carolina for the staff of thirteen regional mental health centers. It lasted for approximately nine months and provided an introduction to marital and family therapy intervention. No statistical reports were made as to the program's effectiveness in reaching its goal.

Other attempts have been made to conquer the problems Markowski and Cain have mentioned regarding training staff clinicians.¹ Issues of live supervision in a training center specializing in structural and strategic therapy were addressed by Berger and Damman.² Byles et al. reported on the training program by McMaster University faculty for the Catholic Charities Association staff in Buffalo, New York.³ Meyerstein documented an ecologically oriented family therapy training program developed for community professionals at a mental health center in Texas.⁴ The use of team family therapy training in teaching conceptual and executive skills to beginning therapists in community

¹Markowski and Cain, "Live Marital and Family Therapy Supervision: A Model for Community Mental Health Centers," pp. 37-46.

²Berger and Damman, pp. 337-44.

³Byles et al., pp. 299-304.

⁴I. Meyerstein, "Family Therapy Training for Para-professionals in a Community Mental Health Center," Family Process, 16, No. 4 (1977), 477-93.

and academic settings was reported by Heath.¹ All of these programs were developed to meet the needs of either trainees or beginning therapists. They addressed specific family therapy approaches (e.g., Structural, Strategic, Transgenerational), were developed around limited time formats, and, aside from the Heath study,² were not designed to include long-term elements of supervision within community mental health or family service agencies.

Within the specific field of marriage and family therapy there have been certain trends toward continued education and training standards for practitioners.³ Only one study was found which considers these needs for continued training in MFT for the staff of community agencies. Markowski and Cain described the process used in a North Carolina mental health center to develop, integrate and maintain a marital and family therapy supervision program for experienced therapists as an ongoing component of the clinic's structure.⁴ The results, problems, and

¹A. Heath, "Team Family Therapy Training: Conceptual and Pragmatic Considerations," Family Process, 21, No. 2 (1982), 187-94.

²Ibid.

³W. Nichols, "Education of Marriage and Family Therapists: Some Trends and Implications," Journal of Marital and Family Therapy, 5, No. 1 (1979), 19-28.

⁴Markowski and Cain, "Live Marital and Family Therapy Supervision: A Model for Community Mental Health Centers," pp. 37-46.

issues of the model are discussed, as well as guidelines offered for those wanting to establish a similar supervision program elsewhere.

Prior to the hiring of an outside consultant for intensive and ongoing supervision, the staff set objectives which were explained by Markowski and Cain:

(a) the program would allow participants to become familiar with various concepts and theoretical orientations especially system-based therapy approaches; (b) the program would provide for the development of therapeutic skills by direct supervision of actual sessions, similar to the process described by Haley; (c) participation in the program would lead toward state certification in marital and family therapy; (d) the program would result in the establishment of a core marital and family therapy group which could function as an ongoing support and supervision group without the need for long-term outside supervision; and (e) because the participants had diverse clinical orientations, the program would permit them to use their own preferred conceptual frameworks when working with couples or families instead of providing supervision in only one specific approach.¹

The consultant hired by the mental health center's staff as an outside supervisor for them met certification qualifications set forth by the American Association for Marriage and Family Therapy as an Approved Supervisor. The consultant contracted with the staff group to work toward the aforementioned objectives. Two clinical teams of six members each were formed, with the consultant hired for

¹Markowski and Cain, "Live Marital and Family Therapy Supervision: A Model for Community Mental Health Centers," p. 39.

one-half day per week to provide live supervision for the therapists.

The supervision groups met seventy-five times and obtained 300 hours of direct supervision. From the accumulated pool of videotaped family sessions a tape library illustrating selected therapeutic skills was developed to be used in ongoing supervision. The original program objectives were accomplished during the first eighteen months. The core group of therapists remaining on staff developed and maintained its cohesiveness, and at the end of the program was providing support and consultation to its members. Due to the strong cohesiveness, processing personal issues was not found to be necessary. Most importantly,

the clinic administration was supportive throughout the program, allowing staff to participate in the group and permitting attendance at outside workshops, conferences, and programs. The supervision group prepared quarterly reports summarizing its activities, including the number of staff participating, hours of supervision received, and the number of families directly served. The reports proved exceedingly important in justifying continuation of the consultation, when budget reductions were considered.¹

The conclusions and recommendations set forth by Markowski and Cain include several important considerations for developing an adequate marriage and family therapy supervision program for an agency. The noted importance of

¹Markowski and Cain, "Live Marital and Family Therapy Supervision: A Model for Community Mental Health Centers," p. 42.

obtaining initial administrative support cannot be overstressed as it affects not only cost management considerations but also the agency procedures and policies. Viewing the family as the client system, rather than an individual, for instance, impacts on third-party billing procedures. Political problems between disciplines on staff may surface. When a staff member from within an agency is chosen as a supervisor, that individual's position in the overall agency organization must be considered.

The center's structure and traditional professional hierarchy might be disturbed, if, for example, a master's level psychologist with appropriate family therapy training and skills was to supervise a PhD psychologist.¹

Similarly, as was learned by Schopler, Fox, and Cochrane and Matthews, there can exist counterproductive hierarchy tension between physician staff and other mental health staff when all are involved in a training program for marriage and family therapy.² Markowski and Cain found the same to be true in their study.³ Finally, the development

¹Markowski and Cain, "Live Marital and Family Therapy Supervision: A Model for Community Mental Health Centers," p. 45.

²E. Schopler, R. Fox, and C. Cochrane, "Teaching Family Dynamics to Medical Students," American Journal of Orthopsychiatry, 37 (1967), 906-11; K. Matthews, "An Interdisciplinary Training Model for Family Therapy," Family Therapy, 8 (1981), 179-85.

³Markowski and Cain, "Live Marital and Family Therapy Supervision: A Model for Community Mental Health Centers," pp. 37-46.

of a core group of clinicians who can function without external supervision should be a long-term goal whenever an outside consultant is chosen to supervise within an ongoing training program for agency staff. The core group, it was learned, can provide an ongoing support group for its members and supervision to other agency staff at the conclusion of the external supervisor's consultation.

The benefits of forming a peer group as one's supervision/consultation group for providing marriage and family therapy have been outlined elsewhere. Much of the focus on these groups has been on providing live supervision for members, or at least the viewing of post-session videotapes.¹ The essentials for inservice training can be determined by surveying what are the actual agency staff's expectations of providing ongoing marriage and family therapy as a primary service, all beyond that which can be

¹J. Allen, "Peer Group Supervision in Family Therapy," Child Welfare, 55, No. 3 (1976), 183-89; V. Olson and P. F. Peggy, "Direct Open Supervision: A Team Approach," Family Process, 18, No. 4 (1979), 463-71; M. Cornwell and R. Pearson, "Cotherapy Teams and One-way Screen in Family Therapy Practice and Training," Family Process, 20 (1981), 199-209; J. Roberts, "The Third Tier: An Ignored Dimension in Family Therapy Training," The Family Therapy Networker, 7, No. 3 (1983), 30.

offered by an ongoing peer supervision/consultation group.¹

Tomm and Wright document what they refer to as a multi-level training and supervision program at the University of Calgary.² They recognize four developmental levels of staff for their relative needs for supervision and training.

Ranging from graduate students, to post-graduate trainees, to trainers and faculty members, their program outlines methods for assessing progress and new training objectives. All levels of experienced therapists work together in an intricate training model. Although what has been documented by Tomm and Wright contains elements of what Markowski and Cain critiqued as time-limited training,³ the multi-level concept has possible relevance in agency applications, especially since graduate students oftentimes receive practicum or internship training by the same staff who have needs for their own ongoing MFT training.

¹J. Rycus, "Essentials of Inservice Training for Child Welfare Workers," Child Welfare, 57, No. 6 (1978), 346-54; B. Matter, "Family Therapy for Continuing Professional Education," International Journal of Family Therapy, 2, No. 1 (1980), 39-46; J. D. Alcorn and D. K. Surgis, "A Model for Adapting Counselor Training to Community Agency Needs," Counselor Education and Supervision, 20 (1981), 243-51.

²Tomm and Wright, "Multilevel Training and Supervision in an Outpatient Service Program," pp. 211-28.

³Markowski and Cain, "Live Marital and Family Therapy Supervision: A Model for Community Mental Health Centers," pp. 37-46.

Summary

The review of the literature has revealed a significant absence of research in the area of marriage and family therapy training and supervision. Much of what has been published recounts the proposals for training program curriculum, or the actual implementation of specific, time-limited programs. With the sole exception of the Markowski and Cain study,¹ no other references are made to an ongoing training program for experienced clinicians in a particular agency setting. The scope of this current study will involve an investigation of what would be needed by experienced clinicians in accredited child and family service agencies for ongoing marriage and family therapy training. The actual design and implementation of a particular model will not be attempted.

¹Markowski and Cain, "Live Marital and Family Therapy Supervision: A Model for Community Mental Health Centers," pp. 37-46.

CHAPTER THREE

Methodology

The purpose of this study was to investigate and describe the continuing needs for supervision and training that exist for marriage and family therapists in accredited child and family service agencies throughout the United States. Specific questions to be answered were: First, is there a diversity of therapy models used by supervisors with staff therapists in accredited child and family services agencies? Second, of those staff practicing marriage and family therapy, how many have received post-graduate training from a recognized family therapy training center or have attained Clinical Member status in the American Association for Marriage and Family Therapy? Third, do staff providing marriage and family therapy receive ongoing supervision, consultation, or training in marriage and family therapy? Fourth, how do supervisors monitor a staff therapist's changing needs for ongoing training? Fifth, is there an actual model applied for marriage and family therapy supervision and training used in child and family service agencies for employed staff therapists?

This chapter will be organized into sections as follows: (1) sampling, (2) instrumentation, (3) procedure,

(4) analysis, and (5) summary.

Sampling

The population used for this study consisted of 296 CFS agencies which have accredited family counseling programs. From this population, a random sample of thirty-eight agencies were selected for a mailed questionnaire survey (Appendix B). A cover letter and questionnaire were sent to the director of each respective agency. The director was requested to have the agency's counseling services supervisor complete and return the questionnaire. In the letter the study was explained and it was requested that respondents not disclose their names or agency names. A return stamped and addressed envelope was sent with the letter and questionnaire.

Twenty-eight supervisors committed themselves to participate in the study by returning their completed questionnaires. The age range of the supervisors responding was 32 to 61 years of age. The mean age was 43.5 years, the median was 42 years and the modal age was 34 years. Fifteen of the twenty-eight supervisors had been supervising for more than five years while two persons had been supervisors for less than one year.

Instrumentation

The questionnaire sent to the agencies for completion by supervisors consisted of twenty-four items. There were

three types of schedule items: open-ended items, fixed-alternative (closed) items, and rank-order items. All items were designed to elicit enough information as was possible to answer the primary and key questions of this study.

Procedure

When the agency directors received the questionnaire, they were requested, in the accompanying letter, to choose from their staff the counseling services supervisor. In some cases this person may have been a practicing supervisor, as well as having had training in marriage and family therapy. It was expected that most, if not all, of the supervisors carried an active caseload in addition to their supervisory duties.

A pilot study of the questionnaire was first completed using a sample population of CFS agencies in the Des Moines, Iowa, area. This was done so as to refine construction problems with the questionnaire used.

Following the actual study mailing and the returning of the completed questionnaires, follow-up letters were sent to agencies having not yet responded with completed questionnaires. These follow-up letters were essentially sent to the majority of the initial sample, with the exception of some agencies which had clearly returned their questionnaires.

The results from the survey were tabulated according to responses made on six out of the twenty-four items on the

questionnaire. Responses on the remaining eighteen items were collected during this study to provide data for follow-up studies on supervision of this author.

Analysis

The purpose of this study was to survey and describe the quantity and orientation of supervision provided marriage and family therapists in accredited child and family service agencies. Specific questions explored were:

1. Is there a diversity of therapy models used by supervisors with staff therapists in accredited CFS agencies?

Research question one was described by a table depicting the supervisor(s)' preference rate for specific models for therapy and supervisor orientation.

2. Of those staff practicing marriage and family therapy, how many have received post-graduate training from a recognized family therapy training center or have attained Clinical Member status in the American Association for Marriage and Family Therapy?

Research question two was described by using a histogram to illustrate the variability and extent of post-graduate training obtained by therapists.

3. Do staff providing marriage and family therapy receive ongoing supervision, consultation, or training in marriage and family therapy?

Research question three was answered by using two different histograms which illustrate the supervision hours spent weekly and the preferred supervision techniques.

4. How do supervisors monitor a staff therapist's changing needs for ongoing training?

Research question four was answered by the use of a histogram depicting the selection rate of particular supervision methods by supervisors.

5. Is there an actual model applied for marriage and family therapy supervision and training used in child and family service agencies for employed staff therapists?

Research question five was answered by the use of a histogram charting the model(s) of choice by agencies.

Summary

Twenty-eight supervisors of accredited family counseling programs in child and family service agencies participated in this study. Each supervisor completed a twenty-four item questionnaire that was mailed to him/her. These questionnaires were returned via mail by the supervisor. Tables and charts were used to describe the data obtained by this study in an effort to learn about the continuing needs for supervision and training for marriage and family therapists in the participating CFS agencies.

CHAPTER FOUR

Results

The purpose of this study was to investigate and describe the continuing needs for supervision and training that exist for marriage and family therapists in accredited child and family service agencies throughout the United States. This chapter presents the results of the findings from this survey. The chapter will be organized as follows: (1) Introduction, (2) Research Question 1, (3) Research Question 2, (4) Research Question 3, (5) Research Question 4, (6) Research Question 5, and (7) Summary.

Introduction

Each research question was answered by the use of a chart, graph, or table. The display of data retrieved from the answers to six of the twenty-four questions in the questionnaire given twenty-eight supervisors was arranged in order to best answer each particular research question. No statistical tests were employed, as correlative relationships were not in the purview of this study. Descriptions of what supervision needs exist currently and how those needs are addressed by supervisors were the primary Purpose of this study.

Research Question 1

Research Question 1 was: Is there a diversity of therapy models used by supervisors with staff therapists in accredited child and family service agencies? Very little of the supervisors' professional background was gathered. In this section information on the supervisors' preferred theoretical model for supervision and therapy will be scrutinized.

Frequency Preference for Supervision

A total of ten possible models were listed for supervisors to rate according to preference usage. An eleventh category, "other," allowed for mention of lesser-known marriage and family therapy models (Figure 1.0). The models listed were categorized into Systems (Structural, Strategic, Milan, Functional, and MRI/Interactional) and Non-Systems (Experiential, Psychodynamic, Intergenerational/Bowen theory, Behavioral, Communication/Humanistic, and other). These categories are according to Gurman and Kniskern's classification.¹

The categorization of models for supervision helps the reader to understand clearly the focus used by supervisors for their supervision. There are two important points to stress when defining these categories. First, systems theories view the client family as the treatment unit.

¹Gurman and Kniskern, pp. 742-76.

SUPERVISOR'S PREFERENCE

<u>PROFESSED MODEL</u>	<u>MOST FREQUENT</u>	<u>MOST FREQUENT</u>	<u>CHOICE RANKING (most times chosen)</u>
★ Experiential	4	4	4th (8)
★ Psychodynamic	7	7	1st (14)
• Strategic	—	6	5th (6)
• Structural	6	4	2nd (10)
• Milan	—	—	9th (0)
★ Intergenerational	3	1	6th (4)
★ Behavioral	—	1	8th (1)
★ Communication/ Humanistic	5	4	3rd (9)
• Functional	—	1	8th (1)
• MRI (Interactional)	2	—	7th (2)
★ Other	1 (Gestalt)	—	8th (1)

• — Systems Grouping (Family viewed by therapist as the client or treatment unit.)

★ — Non-Systems Grouping (Family as either background or context for treatment of an individual.)

Figure 1.0

Frequency Preference for Supervision

Non-systems theories are more apt to regard the family as either the background or context for the treatment of an individual. This definition of who the client unit is--the individual within a family or the family which consists of interacting individuals--impacts directly upon the style and goals of therapy. A second point flows directly from this treatment unit distinction. Those theoretical orientations which tend to emphasize the personal growth aspects of supervision (and, in a parallel sense, the same of the clients of supervisees/therapists) were designated as non-systems. Those orientations which are more likely to focus on defining particular sets of supervisees'/therapists' skills and ways of intervening into dysfunctional families were called the systems group. This categorization does not label, nor take into account, the supervisors' views of family dynamics.

A distinct difference exists between the totals of supervisors choosing a theoretical model for their work. The psychodynamic model(s) was(were) chosen most often as either a "most frequent" or a "second most frequent" model for supervision. The non-systems grouping models were chosen thirty-seven times to the systems grouping of nineteen times selected by supervisors. The clear preference by supervisors for a non-systems model seemed consistent with other data collected (see Figures 3.2 and 5.0).

Research Question 2

Research Question 2 was: Of those staff practicing marriage and family therapy, how many have received postgraduate training from a recognized family therapy training center or have attained Clinical Member status in the American Association for Marriage and Family Therapy? "Recognized family therapy training centers" is represented by the synonymous term of "free-standing institute" (i.e., not university-based and financed) on Figure 2.0.

Source of Postgraduate Family Therapy Training

Figure 2.0 displays the difference in training staff therapists have obtained following their graduate studies. This training could have been concurrent with the ongoing supervision relationship with the agency supervisor. However, it could also have been obtained prior to employment in the agency where the surveyed supervisor works.

Out of a total of 101.5 staff positions (several staff worked part time for some agencies), eight staff therapists had attained Clinical Member status (i.e., less than 8 percent). Thirty-five therapists (i.e., 34 percent) received training from a free-standing institute. A total of over fifty-eight therapists (i.e., 57 percent) had received neither post-graduate training from the AAMFT apprenticeship format nor a free-standing institute. Beyond the limited training in one's graduate degree internship or

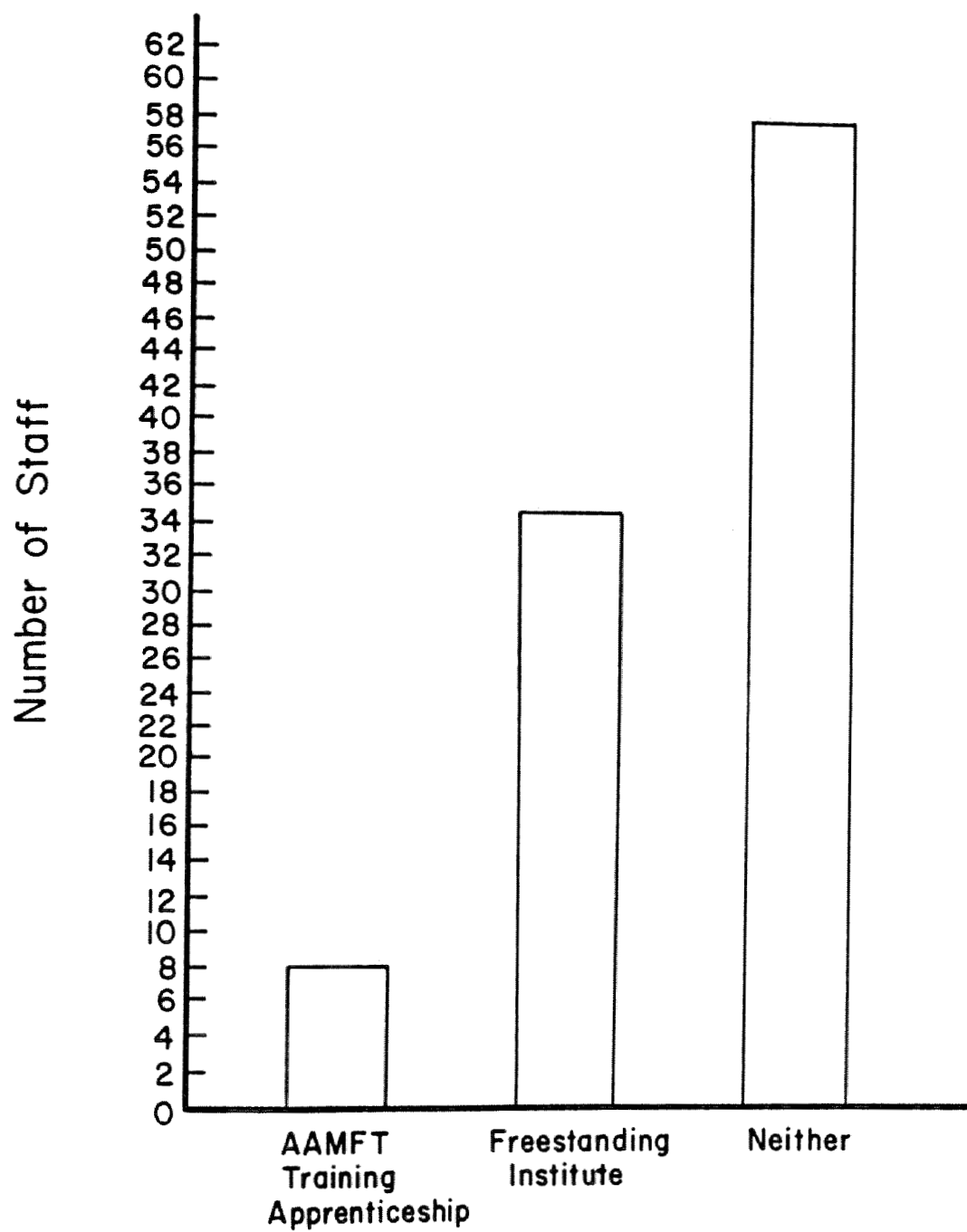


Figure 2.0

Source of Postgraduate Family Therapy Training

practicum, it is unclear where these therapists received training in marriage and family therapy.

Research Question 3

Research Question 3 was: Do staff providing marriage and family therapy receive ongoing supervision, consultation, or training in marriage and family therapy? The question was answered by noting the actual number of supervision hours provided weekly for staff (individual supervision and group supervision hours) (Figure 3.1), as well as documenting the preferred techniques of supervision used. The techniques listed (Figure 3.2) represent varied behaviors in supervision sessions by supervisors, rather than the preferred theoretical model for supervision (Figure 1.0).

Hours of Supervision Provided Weekly by Supervisor

There was a great diversity of reported hours spent providing weekly supervision for staff. Two agency supervisors reported that no supervision was provided staff therapists. It was noted by these same two supervisors that staff either attended workshops or that outside training was occasionally contracted for with an MFT trainer. But in these two instances neither agency supervision nor outside consultation was provided. At the other end of the spectrum one agency supervisor reported that he provided sixteen hours of weekly supervision for a staff of thirty. It

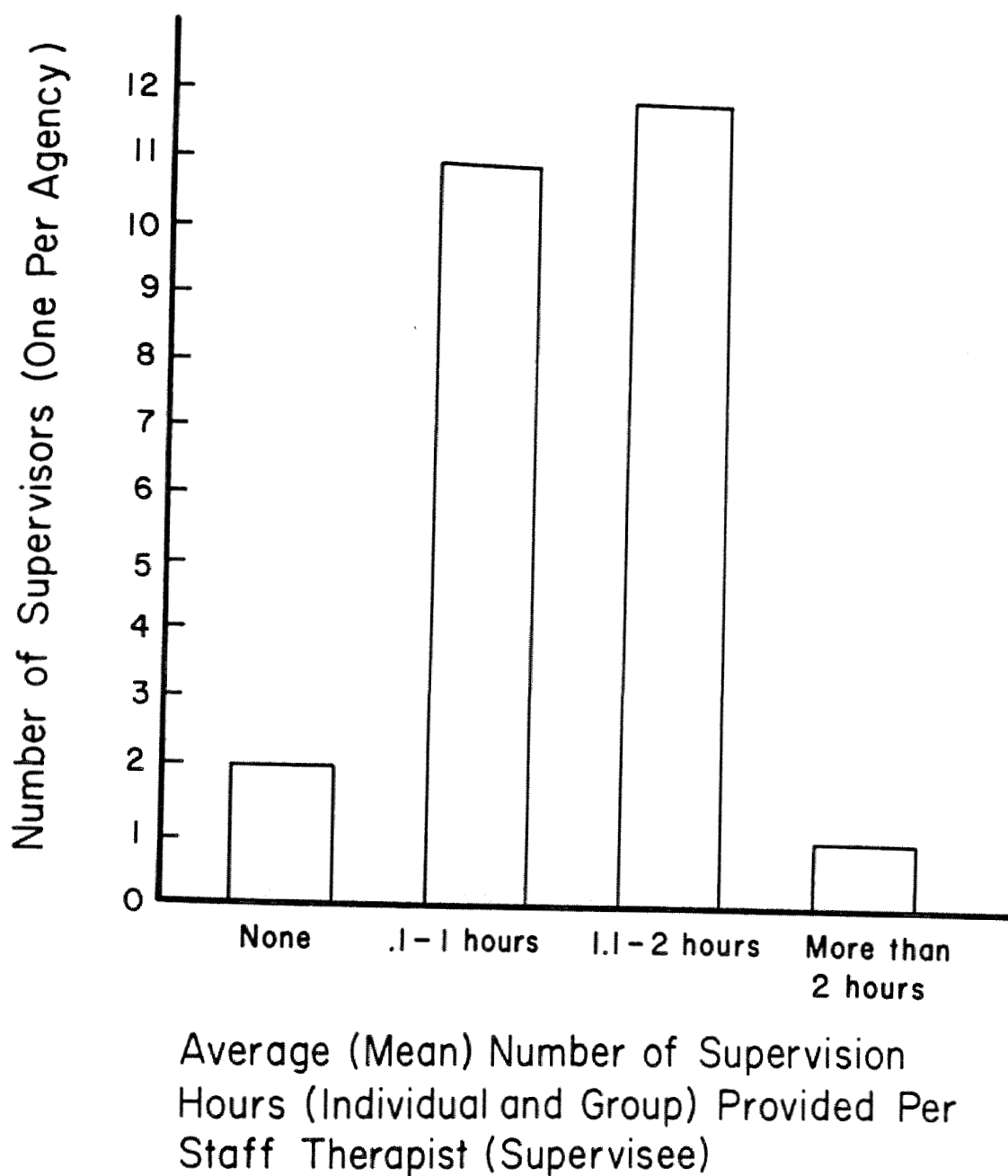


Figure 3.1

Hours of Supervision Provided Weekly by Supervisor

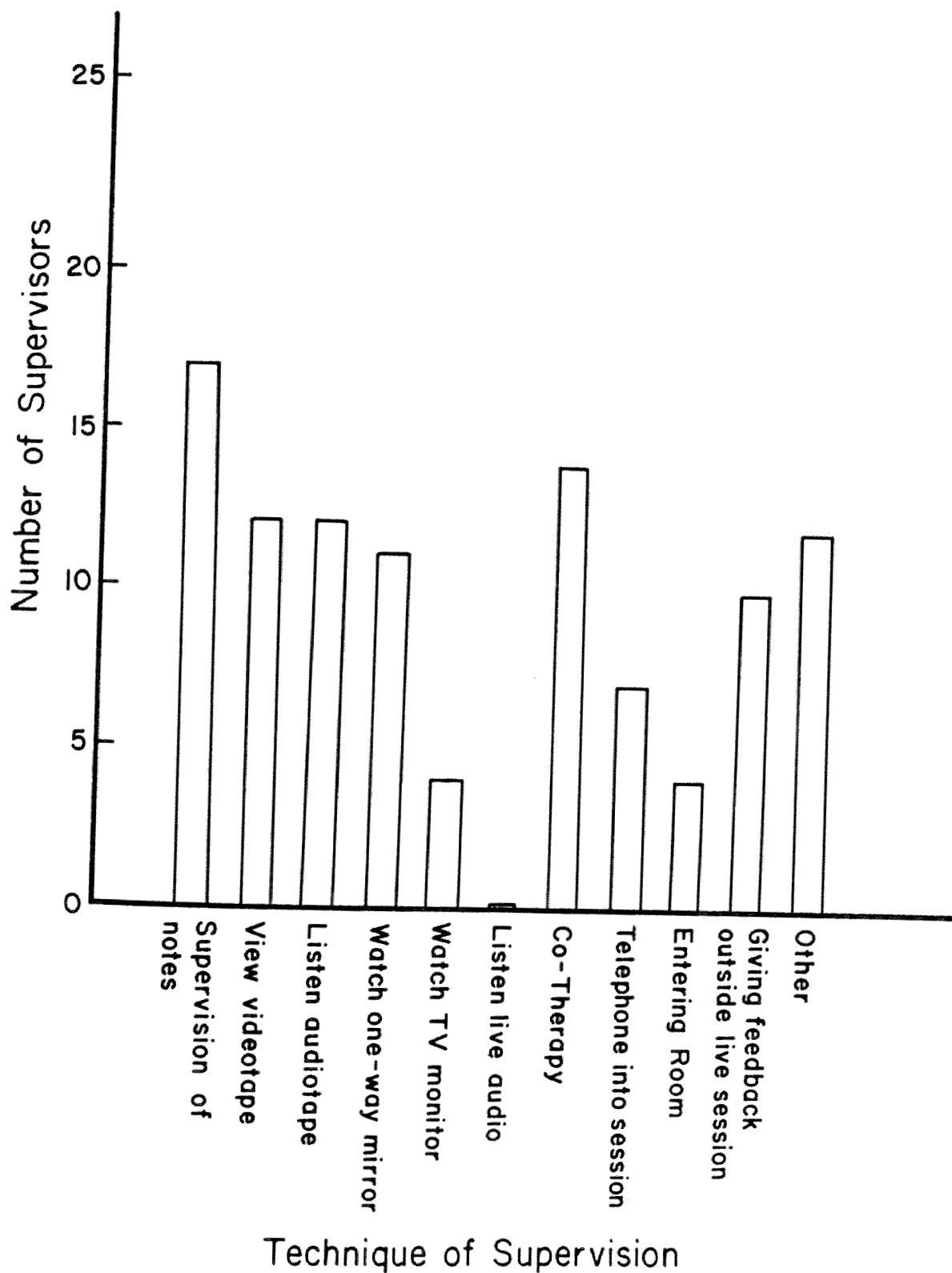


Figure 3.2

Preferred Techniques of Supervision

remains unclear whether this supervisor had thirty fully professional (graduate training) therapists on staff, or whether he had thirty staff members of varying levels of training (professional and paraprofessional).

The average for the sample of supervisor-to-supervisee ratio was 1:6.2 staff. Some supervisors had no more than one and one-half staff to supervise, while another supervisor had thirty. A more indicative and meaningful statistic was the modal number of staff per supervisor, which was eight to one.

In reference to Figure 3.1, one supervisor averaged 2.5 hours per week of supervision (individual and group) per staff therapist. The next highest amount of weekly supervision time was 1.8 hours spent with each supervisee by one supervisor. The modal number of supervision hours spent weekly per supervisee was 1.0 hours (individual and group combined), while the median statistic was also 1.0 hours per week. As indicated by Figure 3.1, twelve of the twenty-six supervisors had weekly supervision averages per staff therapist/supervisee that fit the range of 1.1 to 2.0 hours. The averages given reflect the reports given that some supervisors chose to spend more time with less experienced staff, while a lesser amount of supervision with senior staff. In order to accommodate to the extreme variation in this issue from supervisor to supervisor, it was decided to use the mean statistic rather than modal or

median where reporting graphically the average number of supervision hours provided per staff therapist/supervisee.

Preferred Techniques of Supervision

Figure 3.2 illustrates the techniques preferred by supervisors while conducting individual or group supervision. These techniques are to be distinguished from the preferred theoretical models of supervision (Figure 1.0). Techniques are behaviors utilized in order to provide constructive learning by the supervisee regarding the clinical data being assessed. Models refer to a theoretical rubric within which techniques assume an implicit function. Some techniques may be applicable across all kinds of models. The techniques listed on the horizontal axis are as follows: supervision of written process notes; viewing a videotape of a case; listening to an audiotape of a case; watching a case through a one-way mirror; watching a live case on a video monitor; listening to a live case on an audio monitor; co-therapy with trainee/supervisee; using a telephone to call into a session; entering the room throughout a session; giving feedback outside of the therapy room during a session; others. The last category, "others," included respondent-specified techniques, such as discuss the case afterwards (with no reference to written or taped clinical material), as well as doing family-of-origin work with the therapist/supervisee.

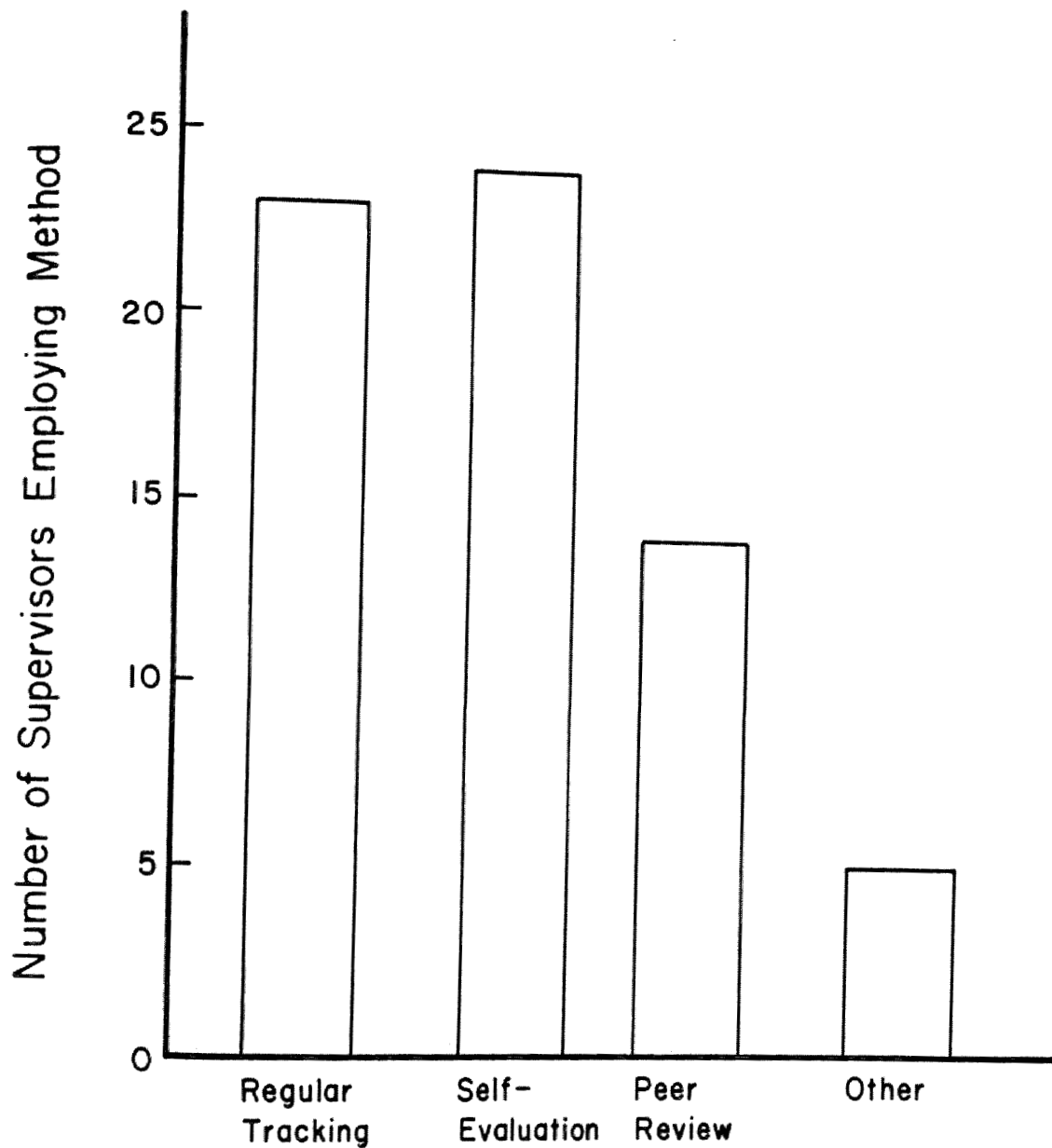
The most prevalent techniques in use by supervisor were supervision of written process notes (17) and co-therapy (14). Viewing a videotape, listening to an audiotape, and the aforementioned "others" were the third most prevalent choices (12). The least-used technique was listening to a live audiotape (0).

Research Question 4

Research Question 4 was: How do supervisors monitor a staff therapist's changing needs for ongoing training? The question was answered by noting the preferred methods of supervision used by supervisors. These methods are not just isolated techniques, nor do they refer to a particular theoretical model of supervision. These methods are a process undergone by the supervisor and/or the supervisee designed to evaluate the clinical effectiveness and skill strengths (or deficits) by the therapist.

Monitoring of Training Needs

Figure 4.0 illustrates the preferences of supervisors when evaluating their staff therapist's (supervisee's) needs for training or for shifts in supervisory focus. As therapists develop skills they have changing needs in regard to deficit areas (e.g., theory refinement, technique sophistication). Figure 4.0 shows three methods of supervision which, along with the category of "other," comprise four possible methods that the supervisor was asked



Methods of Supervision Used To Monitor
Therapist's Changing Needs For Training

Figure 4.0

to check if they are used in his/her supervision process. These methods were not rank ordered. They were merely checked by the supervisor if they were employed methods.

Self-evaluation was considered to be the most prevalent method in use. This method would ask of the supervisee, either verbally or in writing, how he/she evaluated his/her skills and what might be perceived areas for new learning. The second most prevalent method was the regular tracking of one clinical case in depth. This method would involve regular review by supervisor and therapist of a particular case from start to finish, with special attention to the developmental stages of therapy as well as the skill shifts that the therapist was/was not making. Peer review of the therapist's skill and deficit areas was the third most prevalent method used. For those supervisors that had extremely small staffs it is unlikely that this method was checked at least due to pragmatic reasons. The supervisor would not be considered a therapist/supervisee's peer in this regard. The fourth prevalent method section was that of "other." Within this grouping supervisors wrote the following other methods used: "statistical analysis of treatment, goal (clients) attainment review;" "performance assessment;" "client feedback questionnaire;" "review caseload for patterns of strength;" "track several cases in depth, along with educational diagnosis of learning needs;" and "regular tracking of several cases in depth."

Research Question 5

Research Question 5 was: Is there an actual model applied for marriage and family therapy supervision and training used in child and family service agencies for employed staff therapists? This question was answered by displaying the diversity of responses by supervisors to the question of whether the agency within which they work subscribes to a particular theoretical model for its therapy services and staff supervision.

Agency Model for Supervision

The supervisors' responses are displayed on Figure 5.0. Of the twenty-six supervisors (each representing one agency), nineteen answered that there was no model for supervision or therapy subscribed to by staff. Somewhat different, yet similar in the absence of a specific model, was the response by one agency supervisor that the agency prefers to have an integrative model. Although the response was not specific, it may be assumed that the agency in question favored the integration of theoretical models for its marriage and family therapy services and supervision. Integrative in this sense was different than the conceivable response of "eclectic," a descriptor meaning flexibility of model choice rather than an amalgamation of theories into an integrative model (e.g., combination of psychodynamic and intergenerational theoretical models based upon the

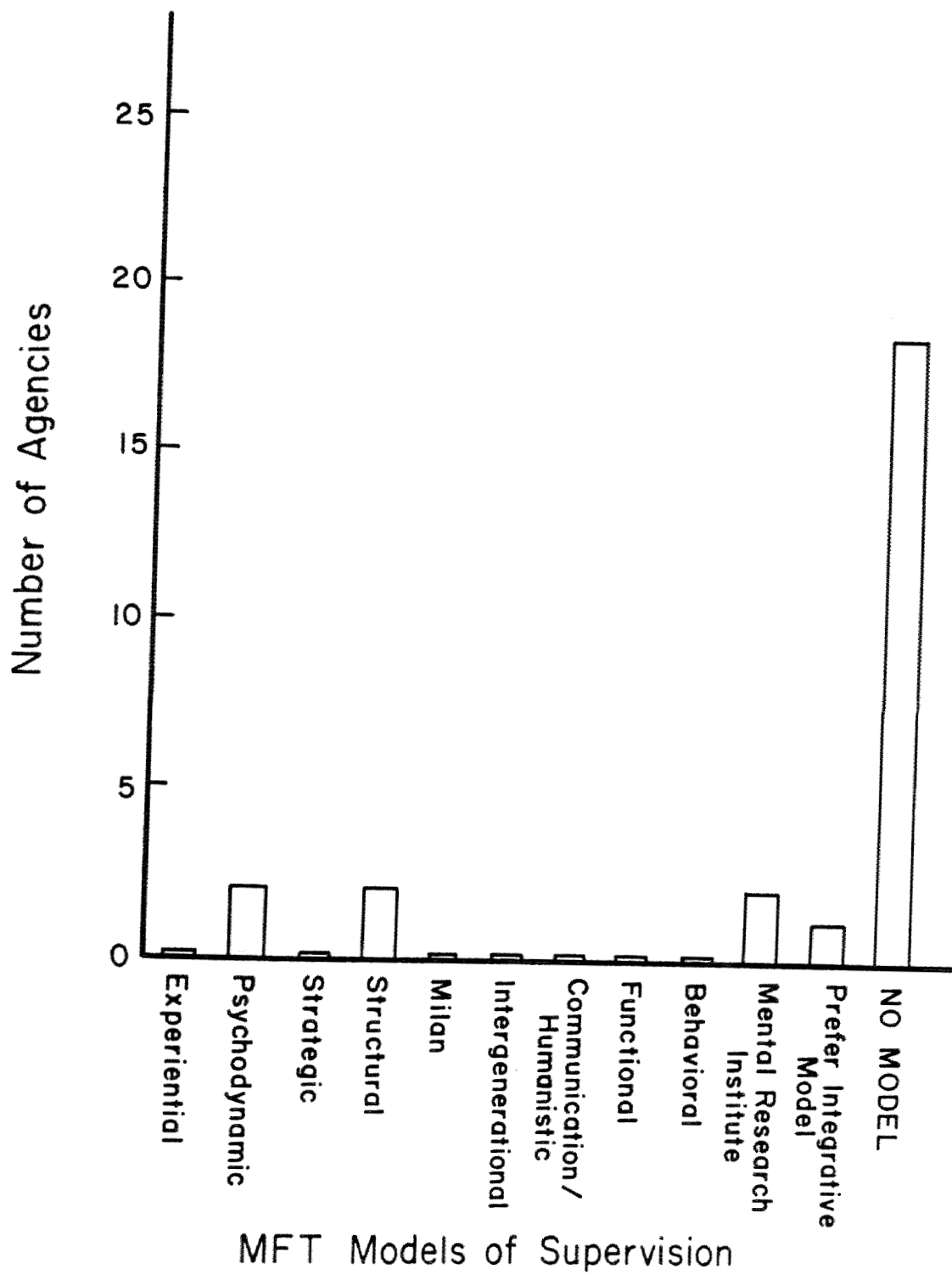


Figure 5.0

Agency Model for Supervision

similarity in historical emphasis for the client's therapy found in each model would be an integrative model).

Three models of supervision and therapy for marriage and family therapists in the agencies studied were specifically selected: Psychodynamic, Structural, and the Mental Research Institute model. Each model was chosen twice by agency supervisors as the specific focus held by supervisor and therapy staff. None of the remaining seven models was chosen as the model used by an agency. (These included Experiential, Strategic, Milan Systems, Inter-generational, Communication/Humanistic, Functional, and Behavioral.)

Summary

A total of six figures was used to describe the data accumulated to answer the five questions of this study. Responses from twenty-six supervisors, one from each agency, constituted the answers to the questionnaire items designed to answer the five questions.

CHAPTER FIVE

Discussion

General Description of the Study

The purpose of this study was to investigate and describe the continuing needs for supervision and training that exist for marriage and family therapists in accredited child and family service agencies throughout the United States. Twenty-six agency supervisors completed questionnaires which were designed to elicit information regarding the nature of the supervisors' staff, their collective training, the theoretical focus for supervision provided, and other questions regarding the professional development needs of staff. These twenty-six supervisors were voluntary respondents from a randomly selected group of agencies taken from a nationwide population of 296 agencies accredited by the Council on Accreditation of Services for Families and Children.

Five questions were investigated in this study: (1) Is there a diversity of therapy models used by supervisors with staff therapists in accredited CFS agencies? (2) Of those staff practicing marriage and family therapy, how many have received post-graduate training from a recognized family therapy training center or have attained Clinical Member

status in the American Association for Marriage and Family Therapy? (3) Do staff providing marriage and family therapy receive ongoing supervision, consultation, or training in marriage and family therapy? (4) How do supervisors monitor a staff therapist's changing needs for ongoing training? (5) Is there an actual model applied for marriage and family therapy supervision and training used in child and family service agencies for employed staff therapists?

Histograms and charts were used to analyze and describe the data for this research.

Discussion of Results

Theoretical Models for Supervision

As Kniskern and Gurman pointed out, the theoretical orientation of the supervisor will most likely exert a perceptible influence on the supervisory dimensions of training and in ongoing supervision of marriage and family therapists.¹ For this reason it is especially important to note the range of theoretical models for supervision and therapy chosen by the sample. Using Gurman and Kniskern's classification of systems and non-systems model groups,² a clear majority of times the twenty-six supervisors chose a

¹Kniskern and Gurman, "Research and Training in Marriage and Family Therapy," pp. 221-38.

²Gurman and Kniskern, "Family Therapy Outcome Research: Knowns and Unknowns," pp. 742-76.

non-systems model as either the "most frequent" or the "second most frequent" reference for supervision. The preference for non-systems approaches for therapy and supervision is not entirely surprising. Child and family service agencies, just as child guidance agencies, have been theoretically informed and guided by psychodynamic theories since the 1940's and 1950's. Additionally, systems models are not prevalent as the primary orientations for graduate schools in social work, counseling, and psychology.¹ Therefore, unless prompted by community variables (e.g., United Way requests for briefer, symptom-focused therapeutic services), agencies would more than likely employ therapists who had been educated in traditional forms of therapy.

Another factor may impinge upon the somewhat lopsided difference (37-19) in supervisor's preferences for systems or non-systems orientations. Most systems theorists advocate the use of videotaping and live supervision (one-way mirrors and/or closed circuit TV monitors). The budget reality faced by many CFS agencies is that there are very limited funds potentially available for purchasing video equipment. Admittedly, some agencies determine those purchases and the remodeling of interview rooms to be service priorities. But for many agencies, the expenditures necessary for systems-oriented training and supervision are

¹Stanton, pp. 433-39.

not worth the change in practice orientation.

Whether there are correlations between the supervisor's age, years of being a supervisor, source of training, and the preferred supervision model might be an illuminating study. This author assumes that those variables may indeed have relatedness of some significance, which, if such were the case, might inform long-range service delivery plans for agencies wishing to change their therapy services in some fashion (e.g., a plan to serve more people with less staff time might necessitate a shift to a symptom-focused, system-oriented form of brief or contextual family therapy).

The literature of marriage and family therapy has recently had a prevalent bias toward systems theory exponents. However, that tendency could easily change in the direction of integrative models that borrow from systems theories and non-systems theories. If that becomes the case, as this author believes it will, then the current practice by agency supervisors may move toward an integrative model for supervision. Given the trends of social work and psychology graduate school curricula to be more non-systems than systems theory based, there would then be less beginning instruction necessary by supervisors with new staff. Teaching a new way of making the wheel takes time.

Postgraduate Training of Staff

It was quite surprising to learn that 58.5 percent (see Figure 2.0) of staff supervised by the respondents had received no postgraduate training in marriage and family therapy from either the AAMFT route or a free-standing institute. While it certainly can be possible that many of these individuals received postgraduate training from other sources, such as workshops, the two tracks given as options are the only recognized formats for training with a format, goals, and time frame of significance (two to three years). The limited percentage of therapists in child and family service agencies that have had specialized training in marriage and family therapy, beyond their graduate coursework and practicum experience, is alarming. The potential may be significant for very naive, inexperienced, and untrained therapists to be employed by child and family service agencies. Given the usually wide range of presenting problems for couples and families who seek services from a CFS agency, a therapist should be prepared to be a specialist and a generalist, simultaneously. Most academic programs are not equipped to train and educate persons adequately to, upon graduation, operate independent of supervision or postgraduate training.

It seems that the variability of pre-employment training and experience for staff providing marriage and family therapy in CFS agencies will someday become a concern

for supplemental funding systems, such as Departments of Human Services or community United Ways. Already this year in Iowa there are now standards mandated by the Department of Human Services for service providers on purchase-of-service contracts with the DHS. Experience levels and academic attainment standards now exist for agency therapists providing home-based family treatment for DHS referred families. This trend undoubtedly will continue as accountability and service efficacy is required by funding bodies which manage decreases or fluctuations in revenue. In order to prepare for those times, child and family service agencies should have consistent experience and training requirements of therapists providing the specialized service of marriage and family therapy.

Supervision of Staff

The results of this study yielded a mixed message regarding whether staff receive ongoing supervision, consultation or training in marriage and family therapy. In most agencies surveyed, supervision, regardless of time duration, was provided each staff therapist, with only two exceptions. The modal and median statistics of 1.0 hours per week suggest that most therapists can expect one hour of supervision weekly, whether that be group or individual supervision. It is not at all clear how the determination is made by supervisors how much time should be spent in group supervision versus individual supervision on a weekly

or monthly basis. How even that question is influenced by the experience level of the staff therapist is yet another significant issue to be determined.

It is not known from the data generated by the instrument whether uniformly the less-experienced therapists received more supervision than the experienced therapists. Some supervisors volunteered comments on the questionnaire that the level of a therapist's experience informed their decision regarding the duration and frequency of supervision provided a therapist. However, there appears to be no magic formula or set of criteria used by supervisors to make an accurate decision on how much time should be spent in supervision. With an eye toward the aforementioned concerns regarding postgraduate training, it seems to this author that certainly a format for determining supervision needs of supervisees should be a segment of the supervisor's overall working contract with each therapist/supervisee. While many supervisors may in fact do so, a clear study of this possibility would help the development of supervision theory and practice for marriage and family therapy in CFS agencies.

The modal staff-to-supervisor ratio of eight to one seems to be somewhat large. Based upon this author's personal experience as a clinical supervisor in a CFS agency, supervision of employed staff requires more time than just the clinical review of their work. Much

administrative time is also included. A staff-to-supervisor ratio of six to one should be optimal, which is closer to the mean staff-to-supervisor ratio of this study (6.2 to 1). Therefore, it appears that in many agencies there may be a slight overload of supervision responsibility ascribed to the supervisor. If such is the case, this author is concerned that an overloaded supervisor may be less available for differing staff needs for supervision, etc. In the longrun, clients suffer when supervisors may be unavailable for the novice therapist.

In the same vein, it was confusing that the most prevalent supervision techniques were supervision of written process notes and co-therapy. The former technique is quite time consuming for both supervisor and therapist. Unless the notes are merely suggestive accounts of the session (in which case they are not truly process notes), therapists must spend literally hours pr week writing process notes of all their sessions. While it is a traditional format for training and supervision dating back to the 1950's, process notes are still consistent with this study's findings that more supervisors chose a non-systems supervision model for their work (e.g., psychodynamic, a model which more than likely requires the use of process notes to evaluate the therapist's prception of a therapy session's process). From a pragmatic and time-efficient standpoint, process notes review is quite time consuming.

The use of co-therapy for supervision is also time consuming since beyond the hour spent together in a client session the supervisor and therapist also spend time reviewing and planning for that sole case. Caseloads for full-time therapists in CFS agencies often run thirty to thirty-five cases at any given time, with twenty-five to thirty appointments scheduled weekly. It seems that the choice of co-therapy, while oftentimes an effective supervision technique, is an inefficient use of time.

One can only speculate as to why such a large use of these two techniques occurs. A possibility may be, as previously discussed on a different issue, that the availability of audiotaping or videotaping is limited. Even if this is the case, the staff time spent in reviewing and writing detailed process notes is far more expensive than a good audiotape machine. And over less than a year's time that same expenditure of expensive staff time could easily equal the cost of a quality videotaping system.

Another more likely possibility arises. Supervisors are just as human as supervisees (although some in the latter group might dispute that apparent fact). Human beings do not always relish change, especially when that change requires them to unlearn some of their past education and make shifts in their perceptions of reality. Using multimedia techniques for supervision review and instruction may require for some supervisors a conceptual shift in their

practice theory and self-perception as reflective supervisors. While some supervisors may be equal to the challenge to be more effective and efficient in their work, others may resist the challenge for personal reasons of discomfort.

Therapist Development and Training/Supervision Needs

The data collected revealed that self-evaluation by the therapist/supervisee of his/her skills and learning needs was the most prevalent method in use by supervisors to monitor staff training needs. Given that more supervisors chose non-systems models for their supervision, rather than systems models, this form of monitoring seems consistent. As Kniskern and Gurman implied in their description of the difference in styles of systems and non-systems supervisors, non-systems supervisors are more concerned with the personal growth of their supervisees, rather than supervise in a directive, problem-oriented way as systems supervisors are apt to do.¹ Giving the supervisee the reins in determining his/her training needs is consistent with a growth, process-oriented style of supervision (i.e., non-directive).

The second most prevalent method of monitoring, that being the regular tracking of one clinical case in depth, was encouraging. Irrespective of the theoretical model bias

¹Kniskern and Gurman, "Research and Training in Marriage and Family Therapy," pp. 221-38.

of a supervisor, he/she can attain the clearest sense of a therapist/supervisee's skill level and development needs by tracking one clinical case in depth. The ability of the therapist/supervisee to stay on track with a treatment plan throughout the early, middle, and final stages of therapy with a client (individual, couple or family) will provide important data for a supervisor regarding skill deficit areas that the therapist/supervisee may have.

Kersey claimed that the developmental level of therapists is an important consideration in supervision and training.¹ He expressed a bias, shared by this author, that developing technical skills is necessary but that it is only one aspect of a developing therapist. Kersey asserted that the overall findings from his study did not support that supervisors took the developmental aspects for supervisees into consideration to any significant extent with marriage and family therapy supervision. He posited that maximizing learning and clinical effectiveness of individual supervisees may take place more rapidly if the developmental level of the supervisee is considered in supervision. This author fully agrees with that hypothesis. Not enough has been done to research the developmental stages of supervisees and the reciprocal steps for supervision. Armed

¹Kersey, "Supervisory Process and Focus Applied in the Development and Training of Marriage and Family Therapists," pp. 1-156.

with better information about those developmental stages (yet to be defined well), supervisors would have a clear perception of supervisees' evolving needs for learning. Without that information, supervision can be bereft of direction.

Agency Model for Supervision

While this author's assumption that supervision occurred regularly in child and family service agencies for marriage and family therapists was essentially confirmed, it was disconcerting to note that such a large segment of the agencies (nineteen out of twenty-six) had no supervision or therapy model. With few points of commonality in theory, language, and practice, how can supervisors be effective with a staff working each from conceivably different stances in their MFT work? Diversity can be a strength for a group of therapists from one agency, yet treatment plan formation would suffer if collegial confirmation was lacking due to differing opinions. Therapists in that kind of setting might feel isolated and risk greater burn-out. This is especially true of beginning therapists.

Reciprocally, if an agency staff holds a very narrow theoretical perspective to their work, that can be delimiting to each therapist's growth. Clinical dogmatism is a form of rigidity equalled only by watered-down eclecticism. The sole agency which holds to maintaining an integrative approach appears to be on the right track. No

one theory holds the truth for supervision of marriage and family therapy. However, without a common channel that joins the best from theories into a unifying, integrative model, there can be very little direction to supervision or collegial support among peer therapists. A balance appears to be desirable.

Although it is well beyond the purview of this study, this author thinks that child and family service agencies could benefit by having a supervision model for staff therapists that is integrative of theory, informed by the developmental stages of a therapist's experience and skills, and adaptable to the demands of supervising a large or small staff. Based upon the data from this study, there is no such model in operation in those agencies surveyed, nor is it likely that it operates in any other CFS agencies, let alone if such a model even exists.

Limitations of the Study

The major limitation of the present study was the size of the sample. Although the return rate from the initial mailing (twenty-six out of thirty-eight) was adequate, a larger sample could have been generated from a larger overall mailing. In general, there was a positive response to the study and several respondents requested that they be sent the study's results. With the same return rate on a larger mailing taken from the total population of CFS agencies, the study's sample size might have adjusted the

data considerably.

Another important fact is that this sample of supervisors was limited by their practice settings. The child and family service setting each operated within is different than other settings, such as hospitals, clinics, and pastoral counseling centers. To generalize the results to these other groups would be inappropriate, even if marriage and family therapy was practiced in those other settings.

Implications and Recommendations

Several implications may be made from the results of this study, especially for child and family service agencies, for therapy supervisors in those agencies, for the marriage and family therapists serving in those agencies, and for further research.

Child and Family Service Agencies

As of this writing, the Council on Accreditation of Services for Families and Children conducts on-site evaluations of counseling services provided by child and family service agencies. These evaluations cover the quality of files, accountability in service delivery, program management, and staff efficiency in service delivery for clients. The Council's evaluations do not study the effectiveness of therapy services, the quality of supervision, nor the monitoring of staff training or

supervision needs. The Council could expect much more from its agencies. By developing evaluation criteria that would measure effectiveness in therapy supervision, supervisors would be on guard to improve their supervision skills. As the clinical quality of supervision is favorably affected, then the therapy provided client families will continue to improve. Supervisors should be well versed in supervision theory, developmental stages for therapists, and the parallel process that occurs in the supervisor-supervisee relationship.¹ This study illustrated the nebulous nature of supervision provided in many CFS agencies. The Council can provide leadership in this arena for its sister agencies.

MFT Supervisors in Child and Family Service Agencies

Every respondent in this study stated his/her preference for methods of continuing education for himself/herself as a therapist and supervisor. Yet there might be some value in having required continuing education for supervisors in MFT supervision (e.g., evolving theories, new techniques, attention to developmental issues for therapists/supervisees). Attendance at MFT supervision workshops and classes could be encouraged by professional associations (e.g., AAMFT, NASW, APA) by offering continuing

¹Doehrman, pp. 3-84.

education credits for completion of those training sessions. The Council on Accreditation of Services for Families and Children might also require such ongoing supervisor training, as well it might for staff therapists to attend therapy training sessions in addition to their regular supervision.

Supervisors might also develop methods to evaluate the effectiveness of their supervision. In other words, do supervisees under their supervision truly become better therapists over time? Is it due to variables, such as the supervision method or style, that can be isolated and evaluated? There are numerous areas for possible improvement of supervision methodologies in CFS agencies. Admittedly, constant review of supervision quality is time consuming, and for sure most CFS agency supervisors are backlogged with tasks to complete, yet the long-range benefactors of improved supervision are the couples and families who come for therapy services. Setting standards for supervisors and therapists alike in CFS agencies would go a long way toward insuring quality client service. Most agency supervisors have considerable influence within their agencies. They can pursue such standards for their own agency, then perhaps others evaluated by the Council.

Agency Staff Therapists

The findings of this study suggest that agency staff therapists providing MFT have an opportunity to evaluate their own needs for ongoing training. Through the method of self-evaluation, each therapist can consider his/her strengths and weaknesses in skill attainment. This opportunity, apparently encouraged by many supervisors, is healthy for the therapists and supervisors alike. Such a regular evaluation process allows for therapists to determine special training sessions and workshops that would provide them with new skills training.

The nature of the supervisory relationship, and its evolving stages of development, may need increased attention by staff therapists. How much of a voice do they have with their supervisors regarding matters of supervisory style, supervisor-supervisee contracts, and improved methods of competency evaluation? Is there a bilateral relationship between supervisor and supervisee in each CFS agency? Can the therapist equally evaluate the supervisor's skills in a formalized, agency-condoned fashion? Supervision differs so from training, or even consultation, as it contains the elements of an ongoing relationship. That relationship should regularly be assessed by supervisor and supervisee for its authenticity, its clear contract for direction, and its flexibility toward the growth needs of the therapist/supervisee.

Research

Despite the recent development of research in the field of marriage and family therapy training and supervision, there is a need for much more, especially in regard to supervision.


This current study answered some important questions. And yet, even more questions were raised by the study than answered. It was learned that most supervisors in CFS agencies do provide marriage and family therapy supervision, but it is unclear what criteria are used to determine the scope and quantity of supervision for beginning versus advanced therapists. Are advanced therapists different than beginning therapists? If so, how? What is conducive to positive development in supervisees? What negative aspects of supervision impair or interrupt positive development? Is an educational/instructional supervisory approach more positive in supervisees' therapy outcome than is a personal growth approach? Is a combination (i.e., integrative) of the best of both approaches better in terms of the therapy outcome of the supervisees? Do supervisees progress from certain stages over six months, a year, two years, or longer?

Research on supervision in different child and family service agencies would be beneficial, especially if dysfunctional and functional systems elements could be identified in order to improve the context for quality

supervision. MFT supervision in child and family service agencies must be rooted in research. Research is not usually a part of CFS agencies, largely due to inadequate funding streams available for research departments. This would be a logical area where CFS agencies could turn to the Council on Accreditation, universities, or institutes specializing in MFT research for assistance.

Conclusions

Child and family service agencies apparently do not have clear standards for postgraduate experience and training for their staff therapists. The MFT supervision provided for therapists in these agencies does not seem to be informed by a supervision model that accounts for stages in a therapist/supervisee's therapeutic and professional development. The scarcity of research on marriage and family therapy supervision has led supervisors to be primarily informed by their theoretical orientations of therapy in general. Also, the majority of the agency supervisors surveyed stated that their agencies did not have a common model that informed the therapy provided clients. Better structure and direction apparently is needed for MFT supervision and ongoing training of staff therapists in child and family service agencies.



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APPENDICES

APPENDIX A
COVER LETTERS

October 8, 1984

Dear Executive Director:

As part of my doctoral research I am sending the enclosed questionnaire to a random sample of agencies in the Council on Accreditation of Services for Families and Children. The research project concerns the style of ongoing training for staff therapists and model ideas for its development. Your assistance in this project would be most appreciated.

Please pass this questionnaire on to your staff person with supervisory responsibility for your agency's Individual and Family Counseling Program? Enclosed is a self-addressed, stamped envelope which can be used for its prompt return. Please do not place any agency or personal names on the questionnaire.

Thank you ever so much for your assistance.

Sincerely,

Douglas B. Stephens, Th.M.
Doctoral Candidate
Drake University

Dear Supervisor:

You are undoubtedly aware of the differences of opinion within the field regarding therapeutic models, supervisory techniques, and the qualifications of clinical staff deemed important. Because of the value of your role in training clinicians, it is necessary to ascertain your current position and practices. Charting these developments will enable us to prepare for future directions, train better equipped therapists, and increase the viability of our field. Please take a few minutes to complete the following questionnaire so that we may consider your professional input. When completed, mail the forms back in the enclosed, stamped envelope. Because you will probably want the opportunity to examine the views and practices of your fellow supervisors, we are more than willing to make available to you a copy of the final results upon request. Answer each question as presented, but feel free to add any additional comments.

Thank you for your time and input.

Douglas B. Stephens, Th.M.
Doctoral Candidate
Drake University

Lawrence E. Fanning, Ed.D.
Faculty Advisor
Drake University

APPENDIX B
INSTRUMENT

1. Sex: Male Female

Comments:

2. Age:

Comments:

3. What is your most advanced degree?

<u> </u> B.S. or B.A.	<u> </u> M.S.W. or M.S.S.W.
<u> </u> M.S., M.Ed., or M.Div.	<u> </u> D.Min. or Th.D.
<u> </u> Ph.D.	<u> </u> J.D.
<u> </u> M.D.	<u> </u> Other, specify:

Comments:

4. How long have you been a therapy supervisor?

<u> </u> Less than a year
<u> </u> 1 to 2 years
<u> </u> 3 to 5 years
<u> </u> More than 5 years

Comments:

5. How many professional (paid) staff do you supervise?

Comments:

6. Of the professional therapists you supervise, how many have Clinical Member status in the American Association of Marriage and Family Therapy (AAMFT)?

How many have received post-graduate training in family therapy from a free-standing institute (non-university)?

Comments:

7. How many direct hours of supervision do you perform weekly with professional staff?

_____ group supervision
_____ individual supervision

Comments:

8. How many direct hours of supervision do you perform weekly with graduate student trainees?

_____ group supervision
_____ individual supervision

Comments:

9. How many graduate student trainees do you supervise?
-

Comments:

10. The following are common techniques and methods used in the supervision of therapy, especially marriage and family therapy (MFT). Please check all of which you employ. Then rank order each item checked according to the frequency in which you use it in supervision or training (1=most frequently used; 2=next most frequently used; etc.)

With Graduate Student Trainees Only

Check Rank

_____	_____	Supervision of written process notes
_____	_____	Viewing a videotape of a case
_____	_____	Listening to an audiotape of a case
_____	_____	Watching a case through a one-way mirror
_____	_____	Watching a live case on a video monitor
_____	_____	Listening to a live case on an audio monitor
_____	_____	Co-therapy with a trainee
_____	_____	Using a telephone to call into a session
_____	_____	Entering the room throughout a session
_____	_____	Giving feedback outside the therapy room during a session
_____	_____	Other (specify)

With Professional Staff Only

Check Rank

_____	_____	Supervision of written process notes
_____	_____	Viewing a videotape of a case
_____	_____	Listening to an audiotape of a case
_____	_____	Watching a case through a one-way mirror
_____	_____	Watching a live case on a video monitor
_____	_____	Listening to a live case on an audio monitor
_____	_____	Co-therapy with a trainee
_____	_____	Using a telephone to call into a session
_____	_____	Entering the room throughout a session
_____	_____	Giving feedback outside the therapy room during a session
_____	_____	Other (specify)

Comments:

11. How often do those you supervise (professional staff or students) have the opportunity to watch you during clinical practice (live or on tape), other than during co-therapy with you?

_____ never _____ periodically _____ quite often

Comments:

12. Using the following scale (1=very effective; 5=very ineffective) rate the effectiveness of these training procedures.

_____ Co-therapy
 _____ Group supervision
 _____ Live supervision
 _____ Individual supervision
 _____ Team live observation of another's therapy session, with supervisor commentary
 _____ Viewing videotapes of supervisee's sessions
 _____ Reviewing case notes of supervisee's sessions
 _____ Family of origin work with the supervisee
 _____ Other (specify)

Comments:

13. In your opinion, how does having those you supervise work on their own families of origin effect the training experience?

_____ Very positive effects
 _____ Somewhat positive effects
 _____ Somewhat negative effects
 _____ Very negative effects
 _____ No effect

Comments:

14. Do you require that those you supervise undergo personal therapy themselves?

Graduate trainees	_____	Yes	_____	No
Paid professional staff	_____	Yes	_____	No

Comments:

15. Please indicate the primary source of your Marriage and Family Therapy training: (specify only the category you consider to be the major source of your training). Check one.

_____ Training institute
 _____ Academic institution
 _____ Apprenticeship with AAMFT Approved Supervisor

Name of above source: _____

Location: _____

Primary model of therapy taught: _____

Comments:

16. How would you describe your choice of therapy models in your supervision? Please check each item that applies. Then rank order each orientation checked according to the frequency in which you use it in supervision or training (1=most frequently used; 2=next most frequently used; etc.)

Check Rank

_____	_____	Experiential (Whitaker, Kempler)
_____	_____	Psychodynamic (Dicks, Martin)
_____	_____	Strategic (Haley, Madanes)
_____	_____	Structural (Minuchin)
_____	_____	Milan (Boscolo, Palazzoli)
_____	_____	Intergenerational (Bowen, Framo, Nagy)
_____	_____	Behavioral (Stuart, Patterson)
_____	_____	Communication/Humanistic (Satir)
_____	_____	Functional (Alexander, Parsons)
_____	_____	MRI (Fisch, Weakland)
_____	_____	Other (specify)

Does your agency subscribe to a particular therapy supervision model? If so, please describe briefly.

Comments:

17. Specify the approximate number of hours you spend per week performing the following professional activities:

Supervision of therapy	_____
Administration	_____
Practice of therapy	_____
Community consultation	_____
Teaching	_____
Other (specify)	_____

Comments:

18. Closest professional identification:

_____	Social worker
_____	Psychologist
_____	Psychiatrist
_____	Marriage and family therapist
_____	Pastoral counselor
_____	Physician
_____	Counselor
_____	Other (specify)

Comments:

19. List in order (1=most important; 5=least important) those activities in terms of their significance to your professional development over the next five years:

_____ Practice of therapy
 _____ Supervision of therapy
 _____ Research
 _____ Administration
 _____ Teaching

Comments:

20. List in order (1=most preferred; 2=next most preferred; etc.) these forms of training in terms of your preference for the style of instruction you wish to experience for your professional development over the next five years:

_____ Didactic workshops or courses
 _____ Experiential workshops
 _____ Videotape reviews with consultant
 _____ Live supervision with intervention (e.g., phone)
 _____ Live observation and subsequent discussion

Comments:

21. List, in order of most important to least important, the topical of professional development you desire for yourself as a clinical supervisor over the next few years, (e.g., week-long workshop series at a free-standing therapy institute on marital therapy techniques).

1. _____
 2. _____
 3. _____
 4. _____
 5. _____

Comments:

22. Number, in order of most important to least important, the areas of ongoing training you feel are most helpful for professional staff (not graduate trainees) (1=most important; 2=next most important; etc.):

_____ Therapy: techniques and style
 _____ Ethics
 _____ Personal growth as therapist
 _____ Therapy research
 _____ Therapy: theoretical issues and special problems
 _____ Other (specify)

Comments:

23. Each therapist goes through developmental stages of sophistication, skill acquisition,, and conceptual understanding of how to conduct therapy. Check the methods you may use in supervision of professional staff which monitor each therapist's changing needs for ongoing training.

_____ Regular tracking of one case in depth
 _____ Request self-evaluation by the therapist of her/his development needs
 _____ Utilize peer review of each therapist's strengths and weaknesses needing more training
 _____ Other (specify)

Comments:

Thank you very much for your responses and the time you spent answering this questionnaire. It is most appreciated. Any comments related to the questionnaire format: